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ABSTRACT

The Postgraduate Medical Institute of the Massachusetts Medical Society had as its goal in this instance to use an interdisciplinary team of consultants to sensitize hospital medical staffs to the unique health care problems of the poor. A consultation model was set up and implemented in three selected hospitals located in depressed areas. The model of consultation is characterized by the following principles: (1) educational consultation is provided by an interdisciplinary team; (2) consultation is used both as a catalyst and as an educational activity itself; (3) consultation stresses critical self-examination as an avenue to insights and corrective measures; (4) consultation seeks participation of individuals who will authorize, effect, and ultimately accept change; (5) consultation starts with recognition of felt problems and seeks to motivate consideration of long-range planning; (6) the approach seeks to maximize consultee involvement in program planning; (7) consultation tries to use educational mechanisms that will assure diffusion of its effects to the staff at large; and (8) consultation seeks to minimize the formation of dependency relationships. (Author/HS)

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CONTRACT NIH 70-4149 (PH 108-69-47)

Develop and Evaluate the Consultation Method in Establishing and Maintaining Educational Programs for Physicians in Three Hospitals Located in Depressed Areas.

FINAL REPORT

A Study of the Use of Educational Consultation to Stimulate Development of Relevant Programs of Continuing Education for Physicians at Community Hospitals in Depressed Areas

Submitted to
Division of Physician and Health Professions Education
Bureau of Health Manpower Education
National Institutes of Health

Submitted by
Postgraduate Medical Institute
30, Fenway
Boston, Massachusetts, 02215

December 31, 1970

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FOREWORD

Contract NIH 70-4149 (PH 108-69-47) was awarded to Postgraduate Medical Institute * on February 3, 1969.

Objectives of the contract included:

A. Select three hospitals located in depressed areas

B. Implement a relevant medical education consultation service

C. Institute programs of continuing medical education

D. Evaluate the effectiveness of the consultation service

E. Collect observations and data describing some of the factors which are important in either aiding or inhibiting the development of programs of continuing medical education

F. Explore methods for evaluating the effect of both program content and technique of presentation on medical practice

G. Analyze, tabulate and interpret the data

H. Identify distinguishing characteristics of hospitals in depressed areas

I. Enumerate distinguishing continuing education habits of physicians practicing in depressed areas

What follows is a final report, in summary form and full text, of activities conducted under the contract.

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* Postgraduate Medical Institute (PMI) is a non-profit, educational corporation sponsored by the Massachusetts Medical Society.

CONTRACT NIH 70-4149 (PH 108-69-47)

CONTRACT SUMMARY*

* Presented as a paper by Norman S. Stearns, M.D., and Robert A. Gold, Ed.M., entitled "Educational Consultation: A Team Approach to Stimulating Hospital Medical Staff Involvement in Health Care Problems of the Poor" at the 1970 Medical Services Conference, sponsored by the Council on Medical Service, American Medical Association, November 28, 1970, Boston. This paper, highlighting activities and outcomes of the contract, is offered here as a preface to the full text of the final report. An expanded version of this summary paper will be published in Medical Care, Volume 10, No. 1, Jan. - Feb., 1972.

Educational Consultation: A Team Approach To Stimulating Hospital Medical Staff Involvement in Health Care Problems of the Poor.

Norman S. Stearns, M.D. *

and

Robert A. Gold, Ed.M. **

Postgraduate Medical Institute believes it possible to use an interdisciplinary team of consultants to sensitize hospital medical staffs to the unique health care problems of the poor.

In recent years there have been exciting developments in the delivery of health care. The literature is rife with reports of experiences and new ideas regarding health care delivery. These proposals, encompassing neighborhood health centers, group practices, pre-paid comprehensive health care systems, etc., have a common, distinguishing characteristic -- CHANGE. They all imply major changes in the conduct of the practice and "business" of medicine. The prospect of change is often threatening. We fear that the agents of change, the activists developing new systems, may fail to divert energies needed to help the medical establishment accept the changes. For most, re-education will be needed, and for many the experience will be painful. Change can be brought about by legislation and rationalization or by education and insight. Postgraduate Medical Institute prefers the carrot of insight to the stick of law. We believe that education is the most desirable technique to close some of the gaps between physicians developing new health care systems and those resisting them.

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* Dr. Stearns is Executive Director of Postgraduate Medical Institute.

** Mr. Gold is Director of Research of Postgraduate Medical Institute.

The Postgraduate Medical Institute (PMI) is the education arm of the Massachusetts Medical Society. Since its inception eighteen years ago, the Institute has been dedicated to fostering continuing education of physicians. Its operations are predicated on the premise that education can ultimately effect improved health care.

For many years we have been using consultation as a stimulus to education program development at community hospitals. In a recent three year study* of the consultation process, we tried to help forty hospitals assess their needs and develop relevant programs. Results of the study demonstrated that intervention by physicians trained as educational consultats significantly affected implementation of elements of continuing education programs for physicians. However, most education activities stimulated were of the classic variety and dealt with familiar areas of medical practice, e.g., grand rounds on "Hypertension", or lecture on "Leukemia".

While this study was in progress, health care consumers in depressed areas were increasingly challenging the medical profession's expertise, responsive and right to define proper health care. Consequently, the Division of Physician Manpower, Bureau of Health Professions Education and Manpower Training, NIH funded PMI to modify and study its consultation techniques when used to stimulate medical staffs of three hospitals to: 1) recognise the special health needs of the poor in their communites, and 2) develop responsive physicians education and service programs.

We will describe the consultation model that was developed and discuss highlights of what we learned while trying to apply the procedure. We thought it important to emphasize the interlocking nature of medical, socio-economic, psychological and cultural aspects of health care problems of depressed area residents and their hospitals. Therefore, the logical direction was to abandon our exclusively physician-oriented consultative focus. In its stead we substituted an interdisciplinary team of consultants. The team consisted of two physicians, a cultural anthropologist, a psychologist, a public health educator and supporting evaluation personnel, used in varying combinations. The team collectively possessed expertise in medical education, community medicine, health care delivery systems, as well as educational and evaluation methodology.

Extending the team concept, we envisioned working with

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*NIH 70-4150 (PH-108-67-170)

a "corresponding" interdisciplinary team of hospital personnel led by members of the medical staff, and including representatives of nursing, allied health and administrative staffs, as well as trustees.

Our intent was to have the two teams examine the depressed area community and the hospital's relationship to it as a "patient", with the health care problems of such a "patient" the subject of discussion. Thus, in addition to its function as an educational catalyst, the consultation procedure itself was to serve as an educational activity.

We selected three dissimilar target hospitals: 1) a large, urban institution in the midst of a black ghetto: 2) a smaller institution in a predominantly low income, white community of high population density; and 3) an institution on the fringe of an economically declining, medium-sized former "mill town" possessing a significant Spanish speaking population.

The consultation process can be illustrated by a description of its evolution at one of the hospitals. The hospital in question is a modern 600+ bed institution located in the midst of an urban ghetto. The hospital was about to begin construction of a multi-million dollar, centralized and specialty-orientated ambulatory care facility. The "neighborhood" adjacent to the hospital contains approximately 20,000 residents, half of whom are Black. There are only three privately practicing physicians in the area, and they do not have admitting privileges at any hospital. The city's poverty program has designated the neighborhood as its top priority target area.

The consultation process at this hospital consisted of four distinct phases: 1) entry; 2) hospital team formation; 3) information gathering; and 4) program planning. Initial entry evolved through informal discussions with members of the administration. At the outset, PMI requested involvement of key medical staff leaders and leaders of other departments of the hospital. We presented our goals, objectives, and the format of the project at a meeting chaired by the president of the hospital medical staff. Hospital representatives included service chiefs, the director of medical education, the director of the outpatient department, the director of nursing service, the head of the hospital personnel department, a member of the social service department and several members of the administrative staff.

The consultation team presented itself as both a direct

stimulant, and as an avenue to resources which the hospital could use to evaluate problems and needs of the surrounding community and to consider appropriate responses. Open discussion indicated that the hospital was not totally unresponsive to needs of the community, but rather that its actions occurred in uncoordinated and isolated instances. Definition, interpretation, and even awareness of the existence of some problems varied from person to person. Many hospital representatives were astonished at the perceptions articulated by colleagues and the apparent communication gaps within their institution. Thus, for example, the chief of psychiatry expressed surprise and displeasure at learing that members of the psychology staff were providing sensitivity training for non-medical department heads in an attempt to increase their knowledge of the supervisory needs of ghetto resident employees. The psychiatrist stated that his annoyance stemmed from not being consulted. Facilitating such frank discussions, and helping to process the feelings they generated, was an important part of our consultative team's job.

At this and subsequent meetings, fragments of the community's perspective were also revealed. The hospital felt its responsibilities ended at its gates and that it should play no part in the political power struggle going on between the local poverty program and city hall over neighborhood funding priorities for health centers. The hospital's ghetto neighbors viewed the hospital as neither removed, nor properly so, from such an issue. The residents felt that the hospital's responsibility should extend far beyond the delivery of health care to those who come to its doors.

Militant Black spokesmen had already confronted the hospital with a set of specific, non-negotiable demands ranging from financial support for community-controlled neighborhood health centers through inclusion of local Black residents on the hospital's board of trustees to being the neighborhood's advocate to the non-ghetto community.

Having long taken pride in the high quality of its medical services, the hospital was at a loss when so challenged. It was both understandable and predictable that the hospital would try to use PMI's efforts and resources to aid handling its immediate problems without having to alter what one hospital spokesman characterized as "a hundred years of doing our thing".

Our response was to urge the hospital to explore the problem more deeply. When the hospital looked for immediate solutions to apparent problems, we frequently responded by asking more questions. Our intent was to mobilize their acute situational anxiety and to transform it into a motivational force which would lead them to pursue more lasting educational and service objectives. The need for more information was established. Equally apparent was the need for mechanisms to share it.

The initial device selected was a hospital-wide information and perception-sharing seminar. To broaded the base of our consultation we included both indians and chiefs, those who could potentially take action, as well as those who could provide insights. Specifically, the seminar was attended by representatives of the hospital's board of trustees, administration, allied health areas, non-medical departments, as well as medical department chiefs, medical staff officers, and those physicians directly involved with operation of the neighborhood health centers.

The seminar's topic was health problems of the depressed community and the hospital's role in solving the problems. A variety of views were expressed including the administration's historical and current perspective, experiences of physicians working in neighborhood health centers, and a summary of the hospital's employment and training programs for ghetto residents. One speaker's sensitive statement of how the hospital looked through Black eyes spurred vivid and heated discussion of latent racism in the hospital.

Now, what of outcomes? First, the fact that such a seminar took place is significant. Second, communication was established between individuals who normally have little or no contact with each other despite common concerns. Third, following the seminar the president of the medical staff sent a letter to every member of the staff which included the following statement: "...the Trustees of the hospital have taken a forward step by recognizing that the geographical boundaries of the property are not the boundaries of the hospital's responsibility for health care. The Executive and Credentials committees have discussed the need for the staff as a whole to make a commitment to help meet the anticipated physician needs, particularly of the.... neighborhood health centers. Each chief has been encouraged to discuss with the members of his service these needs and our possible participation..." The meetings were held, and six months later the neighborhood health centers reported that staffing their clinics was no longer a problem.

The hospital is now providing a small amount of equipment to the health centers and is also allowing the centers to purchase supplies through the hospital at its discount rates. Furthermore, procedures are being instituted to speed-up transfer of records between the hospital and neighborhood health centers.

More recently, the hospital initiated additional education programs which focused on issues and problems surrounding ambulatory care facilities and services. And finally, the hospital announced establishment of an Ambulatory Care and Community Medicine Department. The chairman of the new department indicated that one of the most significant steps taken by the hospital was to give a small group of physicians and administrators power to effectively respond to community needs and problems.

The observed diffusion to the rest of the staff of the ideas generated by the seminar supports the rationale of our consultation strategy: that limited resources of a consultative agency can be used as a catalyst to promote education and involvement of increasing numbers of hospital personnel.

The progress made by this hospital is certainly not to be solely, or even primarily, attributed to our inputs. However, we do think our presence provided stimulus, guidance and support for the hospital's basic willingness to re-evaluate existing structures, functions and relationships when faced with new problems.

In contrast, our efforts with the "mill town" hospital were fruitless. Initially, the administration and some members of the medical staff executive committee demonstrated interest. This interest never spread to the rest of the staff, who were reported to have expressed the feeling that "we need fewer studies and more work". In reality, we suspect our efforts were confounded because we did not take sufficient cognizance of a complicated and delicate internal political situation at the hospital and because we failed to convince our local advocates of the merits of our consultation approach.

At our third hospital, entry was again the greatest problem. Here we departed from our original model. We skipped over

preliminary consultation with a cross-section of staff leadership. Instead, at the invitation of the chief of medicine, we made our initial presentation to a full staff meeting. This tactic backfired. Rather than heightening staff interest, we only aroused antagonism and defensiveness. We were perceived as a threat to the existing education program and the normal decision-making channels. After more than six months of informal negotiations with the chairman of the education committee, and later the medical staff executive committee and the administration, we were able to begin anew. The hospital formed a task force to consider its relationship to the medical problems of poverty area residents and is utilizing a series of guest speakers as a source of ideas. After a slow beginning, the prognosis is favorable.

We feel our approach embraces four central concepts of the American Medical Association's program to improve health services for the poor adopted by the AMA House of Delegates at the 23rd Clinical Convention held in Denver, November 1969:

1) It is a basic right of every citizen to have available to him adequate health care . . . and the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person.

2) The medical profession must take the leadership and actively support constructive community efforts to eliminate those conditions that adversely affect health.

3) The health problems of the poor are basically community health problems, and since a national health program will not solve all of them, programs must be adapted to local needs.

4) Health care to the poor should not be disassociated from, but rather should be a vital part of, the overall health care system.

Successful implementation of action programs, such as that of the American Medical Association, will require involvement of major segments of the profession. Our experience indicates that the AMA still has a major task ahead of it to promote acceptance of the concepts of its action program by state and district societies, and to effect their implementation by medical staffs of community hospitals. Techniques to stimulate physician and medical staff involvement will be needed. We feel the approach described is such a technique.

In summary, the model of consultation that PMI has used to stimulate hospital medical staff involvement in health problems of the poor may be characterized by the following principles:

1) Educational consultation is provided by an inter-disciplinary team;

2) Consultation is used both as a catalyst and as an educational activity itself;

3) Consultation stresses critical self-examination as an avenue to insights and corrective measures;

4) Consultation seeks participation of individuals who will authorize, effect, and ultimately accept change;

5) Consultation starts with recognitition of felt problems and seeks to motivate consideration of long-range planning;

6) The approach seeks to maximize consultee involvement in program planning:

7) Consultation tries to use educational mechanisms that will assure diffusion of its effects to the staff at large; and

8) Consultation seeks to minimize the formation of dependency relationships.

In spite of difficulties cited, the approach described can be a feasible technique to bridge knowledge, service and information gaps between innovative activists developing new health care delivery systems and the majority of hospital medical staffs which are, as yet, uninvolved. But we cannot overstress the effort, persistence, diplomacy and patience needed to translate philosophical positions and paper proposals into real and meaningful improvements in the health care delivery system.

CONTRACT INTRODUCTION

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Need for Continuing Medical Education

In the last two decades, the medical profession has become increasingly alarmed over the inadequacies and inaccessibilities of continuing education programs for physicians. The increasing need for continuing medical education is clearly presented in the November 1967 report of the National Advisory Commission on Health Manpower [1] which called for periodic relicensing of physicians. The report recommended relicensing based either upon certification of acceptable performance in continuing education programs or upon challenge examinations in the practitioner's specialty. Furthermore, in Brune v. Belinkoff, [2] the court threw out the rule which measures a physician's conduct by the standards of other doctors in his own or similar communities. The new standard is whether the physician has exercised the same degree of care and skill as other practitioners in the same specialty, regardless of where they practice.

Many medical educators estimate that the best medical education and training can be obsolete in five years unless physicians make determined efforts to continue their education. Conventional methods of acquiring knowledge, i,e., reading journals and attending professional meetings, are no longer adequate due to the greatly accelerated rate of advances in the theory and practice of medicine, the practical requirements of physicians' normal activities, and changing societal pressures on the profession.

Clearly, the techniques of the past will not serve the diverse and complex needs of today's patients, today's doctors, and today's hospitals. Since the responsibilities of practice and lack of readily accessible programs tailored to the individual physician's practical education impede further educational development, new methods of educational dissemination are necessary. Although enormous expenditures have been and are being directed toward accumulation of medical knowledge, little means-end development has been directed toward diffusion of this knowledge.

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1. Report of the National Advisory Commission on Health Manpower. Washington: U.S. Government Printing Office, November 1967, Volume I., pp. 40:42
2. Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968)

The Community Hospital and Continuing Medical Education

Legislative history accompanying Public Law 89-239 (Regional Medical Program) points out that within the community hospital setting, education programs can be designed to have real and immediate relevance to problems faced by practicing physicians in their daily activities.

Postgraduate Medical Institute, PMI, believes that the community hospital is properly becoming a primary locus of continuing education. More than two thirds of hospital patients are treated at community hospitals. Here too, an education program can be related directly to patient care. Learning is enhanced when physicians and other health care professionals are involved in case presentations, when they seek competent consultation, when they attend educational sessions in an atmosphere which is conducive to exchange of ideas concerning health care of their patients. All of these learning conditions can exist in a community hospital. Therefore, educational programs can be developed there that are responsive both to the health care needs of the hospital's patients, and to the educational needs of the practitioners.

Postgraduate Medical Institute and Continuing Medical Education

In recent years Postgraduate Medical Institute has focused its consultative efforts on continuing medical education program development in community hospitals. The evolution of these views and activities parallels that of the Institute, and is outlined briefly in the following section.

PMI began its activities in 1953 by developing a circuit-riding lecture series for district medical societies and hospitals throughout Massachusetts. However, the post-war demand by physicians for such programs was soon satisfied, and interest in existing formal programs waned. Decline of interest was attributed in part to failure to relate lectures to community hospital educational needs, failure to provide administrative support at the local level and failure to provide educational formats to supplement the isolated lecture.

In September 1961 a new program was established and implemented around the use of consultation to stimulate education program development at community hospitals. This program encouraged community hospitals and their individual staffs to develop their own coordinated programs in continuing education as a service to all physicians in the local community. The basis of the approach was to stress local involvement in identifying local strengths and weaknesses, and

ultimately in planning and executing programs addressed to local needs.

These concepts were implemented and refined during a six year period by two PMI staff physicians working as educational consultants. The potential for rapid expansion of such activities utilizing additional part-time consultants attracted the attention of the Division of Physician Manpower, Bureau of Health Professions Education and Manpower Training, NIH. Consequently, in 1967, PMI was awarded a contract NIH 70-4150 (PH 108-67-170) to consult with forty New England community hospitals and to study the impact of the consultation. The study's preliminary results supported the fundamental efficacy of the consultation process. That is, consultation services by PMI-trained consultants significantly affected the implementation of elements of physician education programs. However, our educational consultants were all traditionally oriented physicians; and the educational activities they stimulated were of the classic variety, utilizing well known techniques of physician education, and dealing with familiar areas of medical practice, e.g., grand rounds -- "Hypertension", or seminar -- "Infectious Hepatitis", or lecture -- "Leukemia".

Depressed Areas, Poverty and Health

The health problems of the poor living in depressed communities are entwined with a vast number of both medical and social factors. Illness is a multi-dimensional problem cutting across economic, educational, political and psycho-social lines. Therefore, a commitment to treat the medical needs of individuals existing at the poverty level cannot be the standard middle class diagnosis, prognosis and prescription. If one is to attend to the medical needs of the poor one must recognize that a stay in a hospital of X days or Y visits to a doctor's office will only temporarily arrest ailments. Recognizing that medical problems of the poor are multi-dimensional, it should be a given that the prescription for cure, whether education or care, must also be multi-dimensional.

Federal statistics indicate that 50% of poor children have never had adequate immunization, 64% have never seen a dentist, 45% of all women who have babies in public hospitals receive no pre-natal care . . . the poor suffer three times more disabling heart disease, seven times more visual impairment and five times more mental illness, retardation, and nervous disorders. It must be assumed that health care delivery systems, as presently constituted, are only reaching select groups of our population.

However, health care of the poor goes beyond the afore-mentioned problems. Sickness, deprivation and social instability are all characteristic of the poor and of depressed communities. Remediation

becomes a monumental task with the inclusion of needs relating to diet, housing, accident hazards, sanitation, drugs, alcoholism, crime and the educational system.

Health care problems of the poor are also rooted in the health care delivery systems themselves. Fragmentation, inaccessibility, inconvenient schedules, lack of effective communication between providers and recipients of health care services, all contribute to the breakdown of adequate health care delivery to the poor. In addition, discriminatory practices in training the poor as health professionals compound existing problems.

Providers and recipients of health care facilities and services in depressed areas are confronted with major communication barriers. The dissonance between the characteristics of each group makes utilization of available services difficult. Establishment of a coherent and continuous community-based health care system is dependent on an understanding by each group of the others needs and functions.

Lack of understanding about preventative health care systems creates a situation in which disease often times goes unchecked until it reaches critical levels. It is only at this time that individuals seek out medical care at either the neighborhood health facility or at the local general hospital. A chief resident at a general hospital in Boston describes this individual as one who comes in with one disease, unaware that he is also afflicted with other pathology which often times severely complicates the treatment of the disease of the primary concern.

Part of the poverty individual's problem is a general lack of understanding about the health care system itself. The communication gap which exists between provider and consumer makes utilization of facilities and service all the more difficult. With the general fragmentation of health care it is no wonder that consumers become confused and frustrated when attempting to use the system.

Too often, primary medical care in poverty areas results in discharge into the environment which characteristically contributed to the malady. The physician must recognize that altering the environment might be essential to eleminating the disease.

Physicians who work within a neighborhood health care model or in an OPD which basically treats the poor often times compound the problems by closing their eyes to the environmental issues involved in patient care. This lack of sensitivity to the needs of the poor generates a situation in which medical care is avoided rather than utilized.

In order to change the situation from what it is to what it should be, it is necessary to define those areas in which physicians should be educated. The 1969 National Health Care Forum [1] enumerated problems relating to the system and physician treatment of the poor. They indicate that the poor cannot obtain medical and dental services, even at minimum standards of adequacy, either because they cannot pay for them, or because those which are available to them without payment (or even with payment) are:

1) Woefully lacking in quality and quantity,

2) Inaccessible because of distance, time, or other practical difficulties,

3) Designed to mete out categorical, mechanical treatment on a "production line" basis; not designed to meet the special needs of the poor,

4) Dispensed with indifference, and more often prejudice and hostility based on race,

5) Dispensed without knowledge of and concern about all the other problems with which the poor live: financial, social, psychological,

6) Staffed by professionals from the outside and not from the disadvantaged area in which they are located,

7) Discriminatory against the poor and especially the black and Spanish-speaking poor, in recruitment, training and advancement for professional and paraprofessional positions.

These issues were coupled with other problems:

1) Fragmentation of health care services,

2) Lack of availability and/or accessibility of needed health services,

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1. Health Care Problems of the Inner City. Report of the 1969 National Health Forum, New York City, National Health Council. March 1969, 115p.

3) Lack of effective communication between health care providers and the people who need the health care services,

4) Lack of consumer control over the amounts, types, hours, or location of health services.

These indicate a need for a revaluation of the health care delivery system, in the light of new forms of education. The traditional system of care will no longer work with the existing environmental conditions.

In order for poverty individuals to be able to utilize the health care systems, new methods of delivery may be needed. Acceptance of the new systems will require educating both recipients and providers.

In 1968, the Division of Physician Manpower asked PMI to try to modify its consultation techniques in order to stimulate development of relevant continuing medical education programs in community hospitals located in depressed areas. On February 3, 1968, contract # NIH 70-4149 (PH 108-69-47) was awarded to PMI to carry out these activities. This document is the final report of the contract.

CONTRACT IMPLEMENTATION

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Phase I Summary

Work proceeded according to the Plan of Progress included in Appendix A. Phase I objectives covering recruitment and orientation of personnel, development of the consultation model and procedures, and selection of hospitals were accomplished on schedule.

Recruitment of Personnel

All necessary personnel were recruited on schedule. Affiliations of all contract personnel other than Postgraduate Medical Institute central staff are included below.

CONTRACT PERSONNEL

Postgraduate Medical Institute Staff

Norman S. Stearns, M.D., Project Director
Robert A. Gold, Ed.M., Project Coordinator
George T. Nilson, M.P.H., Field Director
Marjorie Getchell, M.A., Evaluation and Education Advisor
Marcie Boucouvalas, Research Assistant
Jean Diamond, Research Secretary

Community Medicine Consultants

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Associate Professor of Preventive Medicine,
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Donald A. Kennedy, Ph.D.,
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Tufts University School of Medicine
Thomas Durant, M.D.,
Assistant Director, Massachusetts General Hospital

Research and Evaluation Consultant

Ezra V. Saul, Ph.D., (deceased)
Consulting Director of Research, Postgraduate Medical Institute;
Professor of Psychology, Tufts University

Guest Educators

Herbert Constantine, M.D.,
Chairman, Department of Ambulatory Care and Community Medicine, Rhode Island Hospital;
Associate Professor of Medical Science, Brown University Medical School

H. Jack Geiger, M.D.,
Professor and Chairman, Department of Community Health and Social Medicine, Tufts University School of Medicine

E. Richard Weinerman, M.D., (deceased)
Professor of Medicine and Public Health, Yale University School of Medicine

Development of Consultation Model and Procedures

In December, 1968, a task force consisting of Donald Kennedy, Ph.D., Harvard University School of Public Health; Ezra V. Saul, Ph.D., Tufts University School of Medicine; Thomas Durant, M.D., Massachusetts General Hospital; Norman S. Stearns, M.D., Robert A. Gold, Ed.M., and George T. Nilson, M.P.H., PMI and the Institute's research staff began to actively consider the unique problems associated with the continuing education of physicians in hospitals located in depressed areas. Subsequent to receipt of the contract the task force expanded the scope of its deliberations to include examination of potential target hospitals and alternatives to the type of consultation under study in contract no. NIH 70-4150 (PH 108-67-170). The task force debated the merits of alternate consultation strategies and foci in an attempt to develop a consultation service relevant to problems faced by hospitals located in depressed areas.

A concept basic to PMI's activities and one which was under study from 1967 - 1970 in contract NIH 70-4150 (PH 108-67-170) is that in-person consultation to community hospitals can be used to stimulate interest in the development of continuing education programs utilizing

physicians and others at the local level to plan and implement the programs.

Under NIH 70-4150, PMI consultants for educational program development were all physicians. The programs implemented were of the classic variety utilizing fairly well known techniques of physician education and dealing with familiar areas of medical practice in their subject content, e.g., Grand rounds - "Hypertention", or Seminar - "Infectious Hepatitis", or CPC - "Leukemia", etc.

The purpose of NIH 70-4149 was to develop and evaluate the consultation procedure itself as a teaching technique and as a device to establish and maintain relevant educational programs for physicians in hospitals located in depressed areas.

Consequently, our staff of physicians, educators and behavioral scientists began by pondering the problem of how to best modify our traditional physician-to-physician consultative approach. Our immediate objective was to develop a technique that could prod hospital medical staffs to take a fresh look at the unique health care problems of the poor in their communities.

Our staff realized the importance of emphasizing the interlocking nature of medical, socio-economic, psychological and cultural aspects of the health care problems of depressed area residents and their hospitals. [1] Therefore, the logical direction was to abandon our exclusively physician-oriented consultative focus. In its stead we substituted the concept of an interdisciplinary team of consultants. The team consisted of several physicians, a cultural anthropologist, a psychologist, a public health educator and supporting research personnel used in varying combinations. The constituted team collectively possessed expertise in medical education, community medicine, health care delivery systems, as well as educational and research methodology. This approach was designed to facilitate achievement of our initial objective: to orient continuing medical education activities, including planning, to the specific task of aiding physicians in their

1. See Cherkasky, Martin, M.D., Medical Manpower Needs in Deprived Areas. Journal of Medical Education 44:126-131, February, 1969; and Wise, H. B., Montefiore Hospital Neighborhood Medical Care Demonstration, Milbank Memorial Fund Quart., XLVI: 297-307, Number 3, Part 1, July, 1968

development of programs which would improve the care of patients from depressed areas served by the hospital.

Extending the team concept, we envisioned working with a "corresponding" interdisciplinary team of hospital personnel led by members of the medical staff, and including representatives of nursing, allied health and administrative staffs, as well as trustees, all of whom might, of necessity, be involved in programs of education which seek to further the goal of providing better care to patients from depressed areas served by the hospital.

Our intent was to have the two teams examine the depressed area community and the hospital's relationship to it as a "patient", with the health care problems of such a "patient" the subject of discussion. This reflects another significant modification in our original use of consultation, i.e., in addition to its function as an educational catalyst, the consultation procedure itself was to serve as an educational activity. Thus, for example, instead of utilizing the well known technique of a grand round discussion directed at a given patient with a specific medical problem such as hypertension, we would use consultation as the educational technique focusing on the depressed area community and the hospital's relationship to it.

While making significant changes in our traditional approach to consultation, the new model appeared to still be consistent with the extrapolated principles of adult education, summarized below, on which the original model was predicated. [1]

> The learner must set or accept the program's goals and be involved in program planning.
> The physician/learner should participate in defining the objectives and organization of the program so as to assure its reflecting his interests and needs,
>
> Learning must be problem-centered.
> In order to maximize an educational experience's benefit to the physician/learner, he himself must feel that the

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1. Gibb, Jack R., "Learning Theory and Adult Education", Handbook of Adult Education in the United States, edited by Malcolm S. Knowles. Washington, D.C : Adult Education Association of the U.S.A., 1967, pp. 54-64.

experience deals with a problem he has - not one that the instructor feels he should have. The instructor may recognize what facts, techniques, etc., would be most useful to the physician/learner, but until the learner shares the instructor's insights, maximum learning cannot take place.

Learning must be experience-centered.
The learning experience must be relevant to the patient care problems of the learner. Educational inputs should not be abstract, isolated or "ivory towerish". Basing the educational experience on data relating to the learner's problems will help him accept the learning.

The learner must feel free to openly participate in the educational experience.
An accepting, supportive atmosphere is needed among all those participating in an educational experience. Such an atmosphere will enable the physician to openly discuss what he has done, what he knows, what he may have done wrong and what he may not know. The need for such an atmosphere is clearly evident if the physician is to be encouraged to use his private patients for educational experiences such as grand rounds or audits.

The learner must have feedback about his progress.
In a learning situation where participation is largely based on the physician's self-assessment of his learning needs, it is extremely important that the education program provide him with some means of measuring his progress against his level of aspiration. Program evaluation should help the physician to see the results of his efforts.

Selection of Hospitals

The contract contained no specifications regarding the establishment of hospital selection criteria. A wealth of characteristics exist which might form a basis for selection. Investigation and research of selection criteria resulted in potential candidates being limited to general, short-stay, community hospitals. In addition, a selection procedure evolved which took into consideration six parameters which the task force felt to be relevant, available indices of poverty in the area; plus, the task force's considered

judgment of the suitability of working with particular hospitals. The six parameters included indices of each potential community's: 1) median income; 2) percent unemployment; 3) adverse condition of houses; 4) per cent Negro population; 5) per cent non-white popualtion; and 6) population density.

The limited number of hospitals in the study made unfeasible any attempt to approximate national or regional distribution of hospitals by bed size or geographic location as was done in Contract No. NIH 70-4150 (PH 108-67-170). The investigators chose rather to select hospitals with a view to maximizing the variety of situations in which to examine the effectiveness of the consultation procedure. To that end, hospitals selected included:

1. An institution on the fringe of an economically declining, medium-sized former "mill town" possessing a significant Spanish speaking population; (An effective consulting relationship was not achieved with this hospital. Since the analysis of this hospital's failure to respond may be subjective, it will be designated as Hospital A (H-A) in this report);

2. A large, urban institution in the midst of a Black ghetto; (Rhode Island Hospital, Providence, Rhode Island);

3. A smaller institution in a predominantly low income white community of high population density; (Somerville Hospital, Somerville, Massachusetts).

Profiles of the hospitals and their adjecent communities are included in Figures 1 and 2 below.

Figure 1

Hospital Characteristics

	Staff Size [1]			Bed Size
	Active	Courtesy	Consulting	
Hospital A (H-A)	73*	62	25	252
Rhode Island Hospital	318	37	144*	680
Somerville Hospital	50** plus 13 senior	47*	37	148

1. Categorization of staffs into active, courtesy and consulting is listed as reported by the individual hospitals.

* Dental staff members included in total figures.
Hospital A - 5 active dentists included
Somerville - 27 courtesy dentists included

** Associate staff members included in total figure.

Figure 2

Socio-economic Characteristics [1] of Target Communities

	Hospital A*	Somerville *	South Providence **
% Negro	.4	.4	
% Non-White (Negro & other)	.5	.5	49
% Unemployment	5.2	4.1	8
Median Income	$5679	$6024	$5069
% Adverse Houses deteriorating & dilapidated	14.8	14	48
Density (# people per sq. mi.)	6467	21,967	18,780

1 Characteristics reported comprise those parameters utilized in selection of hospitals for study.

* Data information source - for H-A and Somerville, 1960 Census Tracts and 1965 state census as reported in Town and City Monographs of Mass.

** Data information source for South Providence area - data as reported from findings of South Providence Model City Program's study based on a 10% sample of population. The South Providence neighborhood constitutes the hospital's geographic environs.

Additional support for selection of the three primary target hospitals came from the fact that each is located in a community whose problems warranted its inclusion in the "Model Cities" Program.

Phase II Summary:

Phase II objectives included initial presentations to the hospitals and follow-up consultations to obtain their commitment to the project. The objectives were met on schedule at Rhode Island Hospital (RIH). Achievement of the objectives was delayed at Somerville Hospital and Hospital A eventuating in the contract being entended through December 1970 without additional funding.

Initial Hospital Presentations

Initial contact with hospitals was made via telephone calls or in-person communication to a specific individual (the president of the medical staff or the hospital administrator) taking advantage of personal acquaintances or relationships where such existed. Of each hospital, PMI requested the opportunity to present the "poverty project" to a representative group of the medical staff. In two of the hospitals, Rhode Island and Hospital A, the administration of the hospital was centrally involved from the initial contact onward.

The initial presentation at the Rhode Island Hospital was made to a group that included the chiefs of the various services, the president of the medical staff, the director of medical education, director of the outpatient department, the director of nursing service, chief of hospital personnel, social service representative and several members of the administrative staff.

Doctor Stearns and the late Doctor Saul presented the goal of the program as being to help the hospital and its medical staff better meet the health needs of the poor by introducing or reinforcing modern concepts of community medicine through a series of education-consultation visits. The essential objectives and strategy points covered were:

1. Sell and support hospital (medical staff) commitment to modern concepts of community medicine, e.g., treat community as the patient, i.e., hospital should:

    a. become aware of what constitutes the total patient;

b. assess medical care needs of the patient;

c. assess hospital, physician, etc. resources;

d. assess what needs are not being met and why;

e. develop new education-care programs to meet unmet needs and/or bolster medical staff in critical areas.

2. Assist hospital (through consultation-education sessions) in conceiving, conducting and/or supervising assessment of its patient (community).

3. Assist hospital (through consultation-education sessions) to develop new education-care programs based on their own assessment of needs.

Our goal was to introduce an approach and to help the hospital understand how to use it - we did not intend to do it for them.

This basic presentation with slight variations was made by Dr. Stearns at a regular medical staff meeting of the Somerville Hospital on April 15, 1969, attended by approximately thirty physicians. The hospital permitted only a formal presentation and did not allow time for discussion and feedback. (Dr. Stearns was introduced as "today's speaker").

Dr. Stearns, Dr. Golodetz and Mr. Gold made the initial presentation of the project to the Hospital A on April 17, 1969. Present at the meeting were the medical education committee (numbering eight physicians), the president of the medical staff and the hospital director.

Follow-up Consultation

At each of the target hospitals, one or more intensive consultations were required, subsequent to the initial presentation of the project, before lasting commitment was obtained. These consultations were geared to helping the hospitals see a need for the type of approach to educational

program development that we were proposing. In some cases resistance, seemingly based on defensiveness, had to be confronted and worked through in a manner characterized by one of our consultants as "not far removed from group therapy".

The Rhode Island Hospital, perhaps not incidentally experiencing the most community pressure, was the most responsive. A series of consultations involving Dr. Kennedy, Dr. Golodetz, Dr. Saul, Dr. Stearns and other members of the PMI staff and a core group of the Rhode Island Hospital resulted in a solid commitment to the project as reflected in the appointment of a medical coordinator and administrative staff back up. A special "situation room" was set aside at the Rhode Island Hospital, at the suggestion of Dr. Kennedy, for the purpose of gathering, collating and visually presenting data relevant to the poverty community served by the hospital. By the end of phase II a meaningful relationship had been established between the PMI "poverty team" and the Rhode Island Hospital that was to be a significant factor in assisting the hospital and its physicians to cope more creatively and positively with the health care needs of the poor people in its service community.

Following initial presentation of the project at Somerville Hospital, eleven months of Phase II negotiation, consultation and prodding transpired before the hospital formally committed its participation. During that time PMI initiated follow-up contacts with the hospital a total of ten times, resulting in submission of a formal seven page proposal to the hospital, two in-person consultations, and a number of telephone consultations.

A series of these telephone consultations during the remainder of the spring and summer of 1969 finally stimulated the hospital, in late September, to request a formal written outline of the approaches and programs that PMI was prepared to pursue. The hospital physician who was then acting as our liaison, and who supported our efforts, felt that a concrete written proposal, offering several options, would have the best chance of being approved by the medical staff executive committee.

The requested outline, designed to provide a focus for the committee's reconsideration of the project, was developed

and forwarded to the hospital on October 14, 1969. A copy of the outline is included in Appendix B.

On December 19, Dr. Stearns and Mr. Gold were invited to a meeting of the executive committee. The hospital's administrator was also in attendance. The committee apparently had met previously and discussed the proposal. They now asked for additional clarification of the kinds of activity the hospital would be asked to engage in if it participated.

Dr. Stearns outlined the goals of the contract stressing its flexibility in terms of the types of activity that could take place within its framework. Dr. Stearns also reinforced the meeting chairman's invitation to those physicians present to share their individual experiences and insights regarding the scope of some of the problems in their community. This was done to (1) illustrate PMI's objective of helping the hospital see the value of systematic examination of the medically related problems of the people in depressed areas and (2) provide an actual educational experience for those present.

Thus, for example, the chairman of the executive committee reported the existence in Somerville of a committee including two physicians, and representatives of charitable and other interested groups. Several physicians present claimed that this was "the" committee responsible for dealing with problems of the poor. Dr. Stearns" questioning uncovered the fact that the committee had no formal connections to, or delegation of responsibility from the medical staff of the hospital. Those present seemed to agree with Dr. Stearns that this information pointed to the need for open discussion among the medical staff of the status of current activities vis-a-vis medical problems of people in depressed areas.

At a later point in the meeting, the community's only practicing pediatrician noted that since the introduction of medicare he was seeing more of the "very poor" than he did previously. When the administrator noted that there were 30,000 potential pediatric patients in the community it was obvious to those present that there still was room for concern at least in this area.

Time limitations forced the premature termination of the

process. The chairman of the executive committee indicated that following further in-hospital deliberations he would convey the hospital's decision regarding participation in the project. The consultants left the meeting exhausted, but encouraged by the feeling that they had been able to bring their point to life.

About two weeks later the chairman of Somerville's education committee requested a meeting with representatives of PMI. (It should be noted that our initial approaches to the hospital were made through another physician, the chief of medicine, hoping that a personal relationship and his known support would aid our cause). The committee's chairman indicated that he had been appointed chairman of an ad hoc committee to evaluate our proposal. He said that he attributed the negative response to our first presentation to a reluctance on the part of the staff to proceed with an educational endeavor that might potentially compete with the hospital's existing continuing education program. He thought that progress could now be made if our project was funneled through the existing continuing education channels that he headed.

As such, the purpose of his visit was to re-establish the basis of an acceptable working relationship.

After a lengthy discussion of background information, the remainder of the meeting was devoted to consideration of an acceptable model for a program at Somerville Hospital. A program goal of developing staff understanding of the medical needs of people in depressed areas was agreed upon. Selected as a first step was the establishment of a staff committee to provide opportunities for communication as the hospital community, led by its medical staff, examined its role, vis-a-vis, the medical needs of the poor. The proposed committee would be composed of the chief of staff, the community public health officer (member of the hospital staff), chairman of the education committee, the administrator or his representative, a social worker, a nursing representative, and representatives from the departments of medicine, pediatrics, surgery, general practice, and ob-gyn.

Additional consideration was given to the potential uses of speakers or consultants as either resources to the committee or as speakers in a more formal education program.

At the conclusion of the meeting the DME seemed favorably disposed toward PMI and the project. He indicated that he would present the outlined program, as well as his full understanding of PMI and the project, to the ad hoc committee; it, in turn, would make recommendations to the executive committee or the whole staff regarding participation in the project.

Thus, two months before the hospital formally agreed to participate, concluding Phase II activities at this hospital, we were well along with Phase III's objectives of planning and implementing education programs.

The process of obtaining commitment initially appeared to have held true to form at Hospital A. Following our initial presentation at the hospital only one additional in-person, clarifying follow-up consultation and several telephone calls were needed to produce a paper commitment from the medical staff executive committee and the hospital's director, indicating that the president of the staff would serve as our liaison.

More detailed discussions of the processes involved in obtaining the hospitals' commitments to the project, as well as analyses of the problems encountered, may be found in the evaluative case studies included in the Phase IV section of this report.

Phase III Summary

As indicated earlier, difficulties encountered during Phase II delayed its implementation and resulted in the need to extend the contract beyond the original expiration date without additional funds.

Activities of Phase III (Consultation to develop and Implement formal educational programs) were telescoped over the extended contract period. Phase III objectives were fully realized at the Rhode Island and Somerville Hospitals, but were not achieved at Hospital A.

Teaching Consultations, Education Program Planning Consultations, and Formal Education Programs

Having obtained Rhode Island Hospital's commitment through our initial presentation and a follow-up consultation, a series of consultations ensued, ostensibly held to "plan" a series of "education programs." As anticipated during our revision of the consultation procedure in Phase I of the contract, these "planning" consultations were in themselves significant educational activities. Thus, in the process of "planning" educational programs, the consultation team was kept busy "teaching" the hospital a practical approach to program planning which centered on identifying and utilizing sources of information that would allow the hospital to:

1. become aware of what constitutes the total "patient";
2. assess health care needs of the patient;
3. identify relevant hospital, physician, etc., resources;
4. assess what needs and problems are not being met and why;
5. develop new education-care programs addressed to the unmet needs and problems;
6. evaluate the impact of the programs.

As will be seen later, this approach was both practical and fruitful, yielding completely unforeseen sources of information.

The first formal program outgrowth of the planning consultations was a decision to hold an extended, hospital-wide seminar

to provide an opportunity for the mutual sharing of knowledge, perceptions and opinions regarding (1) "health" problems of the depressed community and (2) the most appropriate role for the hospital to play in the solution of those problems.

PMI provided guidance regarding target populations, educational methodologies, composition of the group, date, duration and location of the session, and its evaluation. (See Phase IV, page 72 for a report of the evaluation of the seminar conducted by the hospital at the suggestion of PMI. The format selected for the seminar called for participation by representatives of the hospital's board of trustees, administration, allied health and non-medical departments as well as medical staff. The hospital and PMI viewed the inclusion of these participants as a significant and innovative approach to the development of relevant continuing physician education. (A series of follow-up educational sessions within individual medical services were also planned.)

In addition to providing consultation leading to the development and acceptance of the idea of the seminar, PMI also directly prepared some educational materials and suggested others for use in connection with the seminar. In particular, PMI prepared a twelve page edited collection of news clippings pertaining to issues of general health care delivery systems and their particular manifestations in South Providence (see Appendix C).

The hospital also accepted PMI's suggestion to provide a reprint of an article entitled "The Neighborhood Health Center - Reform Ideas of Yesterday and Today"*, a booklet distributed by the National Tuberculosis and Respiratory Disease Association entitled Poverty and Health, the Problem/Roots of Change; a map of Providence showing the location of Rhode Island Hospital and Neighborhood Health Centers; and a brief description of the whys and wherefores of PMI's presence at Rhode Island Hospital.

The execuitve Director of the hospital invited participants to the seminar entitled, "Seminar on Community Health." The meeting was convened at a motel near by the hospital on July 23, 1969, from 4 to 9 p.m. Participants included: 2 hospital trustees, 7 administrators, 17 physicians, 2 psychologists, 3 nurses, 8 members of non-medical departments, 3 PMI staff members, and 3 PMI consultants. Most participants occupied leadership positions in their respective hospital areas. The PMI consultants included:

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*New England Journal of Medicine. 280:1385-1391, 1969

Arnold Golodetz, M.D., Associate Professor of Preventive Medicine (Tufts University School of Medicine); Donald Kennedy, Ph.D., cultural anthropologist and assistant director, Center for Community Health and Medical Care (Harvard University School of Public Health), and Ezra Saul, Ph.D., (deceased) Professor of Psychology (Tufts University). All participants received folders containing the educational materials described earlier.

Two formal, two-hour working sessions took place before and after an hour long informal discussion over dinner. Both types of interaction provided a unique opportunity for exchange of views among people who normally have little commerce with each other in the typical patterns of hospital function.

After an opening charge by the Chairman of the Hospital's Board of Trustees, the executive director of the hospital gave an historical account of the evolution of the hospital's relationship to the neighboring community. Special attention was paid to events occurring since January, 1969 when the hospital was first confronted by a group of militant community residents bearing a list of demands that would require a change in the hospital's definition of its relationship to the community. The events, as outlined by the hospital's executive director, included picketing, confrontations, repeated negotiations and extended deliberations which led to the hospital's current reconsideration of its proper role and relationship to the community.

The Directors of Personnel and Public Relations, Psychology, Nursing, Ambulatory Services, a Rhode Island Hospital physician working in a Neighborhood Health Center and others were subsequently called upon to present their varying perceptions, analyses and opinions regarding the hospital-community situation and the hospital's responsibility for the improvement of health care and health-related socio-economic problems in South Providence. These presentations spurred vivid, sometimes heated discussions.

A slide show depicting the living conditions in the slums abutting the hospital's grounds was prepared by the hospital administration and presented during dinner. The two-hour period after dinner included inputs by PMI consultants and further discussions by the seminar participants.

A more detailed account of the seminar's content and process is included in Appendix D. Because of its innovative character, complete proceedings of the seminar are included in this report as a sample educational program.

The full impact of the seminar and the ensuing service-wide sessions is analyzed in the Rhode Island Hospital Case Study in the Phase IV section of this report. However, one outcome is worth extra note here. The observed diffusion phenomenon, i.e., a spreading of the ideas generated by a limited group (the seminar) to the rest of the staff (via the hospital initiated and run follow-up sessions) evidences the feasibility and utility of PMI's fundamental education-consultation strategy: that limited resources can best be utilized in a catalytic fashion to stimulate others toward self-education.

To render consultation regarding the planning of further educational programs, a team of 3 PMI staff members met with the liaison physician and several administrators at Rhode Island Hospital on November 14. The Rhode Island Hospital liaison physician pointed out that in the wake of the July seminar and ensuing small group meetings among the medical staff, a large portion of the medical staff of Rhode Island Hospital had become familiar with the concept of community health and with the philosophies and views held by various members of the hospital community.

The liaison physician and administrators present thought that it would now be useful to provide the added stimuli of fresh ideas from outside sources. A new set of educational programs bringing nationally known figures in community health and social medicine to the hospital were envisioned as the vehicle for such stimulation. Such individuals would be asked to relate their concrete experiences and problems encountered in working with innovative health care delivery systems in depressed areas. Hope was expressed that such communications regarding actual programs and their functioning would, in turn, stimulate the staff to further deliberations regarding what is feasible and advisable in the Rhode Island Hospital situation. In particular, the following plan emerged:

1. Invite a nationally known figure in the field of community oriented health care, ideally for 1.5 or 2 days.

2. Allow him to familiarize himself with the community situation and the hospital via personal observation.
3. Have him meet with the Ambulatory Services Committee as a consultant.
4. Have him meet with a seminar group (similar to the one on July 23) for dinner and discussion.
5. Have him deliver an address to a joint medical-surgical meeting Saturday morning. Subject matter to be his experiences in developing and implementing his program.
6. Periodic small group meetings should follow during the weeks after these programs.

A tentative target date of late January - early February, 1970. was set for the first program. Those present from Rhode Island Hospital agreed to confer and develop preliminary plans regarding time, speaker and target audience. PMI representatives agreed to also think about potential speakers. A list of recommended guest-speakers was sent to Rhode Island Hospital by PMI in December, 1969.

In late December the hospital confirmed that the late E. Richard Weinerman, Professor of Medicine and Public Health, Yale Medical School, would be available for activities at RIH on Friday, January 30, but could not stay for Saturday. Under these circumstances, the liaison physician did not consider it feasible to have Dr. Weinerman directly address the majority of the medical staff (as planned for the medical-surgical grand round on Saturday), stating that in the past the hospital had not been able to attract large numbers of the medical staff for Friday activities. Though PMI urged the hospital to attempt a presentation with the general staff anyway, the hospital declined. All other aspects of the visit, however, were in keeping with the plan outlined above.

Dr. Weinerman spent all day at RIH as a consultant, addressing and consulting with various groups including the service chiefs, the ambulatory care committee, and the administration. In the evening, a reception and dinner meeting was held at the University Club in Providence for an invited group of 40 to 50 people (medical staff and allied health leadership, administration and trustees).

During the day, Dr. Weinerman became familiar with the RIH - community situation, inspected hospital and neighborhood

facilities, related his own ambulatory care experiences at Yale-New Haven, and made recommendations. After dinner, he outlined questions and issues to which he felt the hospital should address itself. These included the following:

1. Ambulatory care cannot and does not exist isolated from the rest of the hospital-community complex of needs and health care.
2. The ambulatory care"problem" (a new 25 million dollar edifice under construction, in the case of RIH) cannot be addressed out of context with the rest of the health care delivery system.
3. The health care system must include a community-based system of primary care and referral as well as the hospital's specialty oriented ambulatory care clinics (67, in the case of RIH). Such a system would integrate continuity of personalized care with specialty care of high quality.
4. Advocating the "principle" of a community-based system of primary care as a foundation for the ambulatory care system, Dr. Weinerman indicated that the primary care component could be implemented through private physicians, neighborhood health centers, group practices, etc. as dictated by local conditions.
5. Such a system must be reinforced where existing, and developed where lacking. Institutions such as RIH, while not solely responsible, should support the effective establishment and maintenance of such an overall system of health care for the community it serves.
6. RIH might develop and maintain a model primary care delivery unit.

Evaluation of the day by the program's planners was favorable. Prior to his sudden and tragic death a month later, plans were already underway to have Dr. Weinerman return for additional educational programs. Though a more complete account of subsequent activities and outcomes at the hospital is included in the RIH Case Study in the Phase IV section of this report, we would offer one observation here. The fact that only one planning consultation meeting preceeded this second major education program, as compared with many such meetings required for the July seminar, evidences the educational value of maximizing the consultee's involvement in program planning as well as the achievement of a non-dependency relationship in the consultation.

Soon after the objectives of Phase II (commitment) appeared to have been achieved at Hospital A, progress slowed at first and then stopped entirely.

By June of 1969 several consultations had produced tentative agreement to develop a session similar to the seminar then in planning at RIH. The preliminary plan called for a luncheon meeting with the Executive Committee, Trustees and physicians from the outpatient departments. The meeting, projected for the fall, was to focus on "consideration of the Hospital's role in the community". The hospital's representatives were not yet prepared to accept PMI's suggestion that community, social work, OEO, etc. representatives should also be invited.

Several additional proddings by PMI, in late summer and early fall, aimed at finalizing plans and schedules for the seminar were not successful. The delay seemed to reflect a degree of insecurity on the part of the hospital regarding their ability to succesfully introduce and implement this new type of education (both content and format). Repeated efforts by PMI failed to move the hospital and further attempts to involve it were abandoned.

As indicated at the end of the Phase II discussion, by January 1970 a new and effective modus operandi had been established with Somerville Hospital. The new liaison physician supported our efforts, and in March the executive committee voted to accept his recommendation that the hospital participate in the project.

A series of consultations resulted in a decision to initiate educational sessions geared to the health care needs of depressed area residents. These special programs were integrated into the hospital's existing continuing medical education activities.

The first program centered on a presentation by Dr. Jack Geiger, Professor and Chairman, Department of Community Health and Social Medicine, Tufts University School of Medicine. Dr.

Geiger discussed and contrasted his experiences in developing and operating primary health care services for people in depressed areas, including the Columbia Point program in Boston and the Mt. Bayou project in the Mississippi delta region. A lengthy discussion then ensued regarding potential applications in Somerville.

Following a summer recess in the education programs, another special program was planned and conducted in October 1970. This time the guest speaker was our RIH liaison physician, Dr. Herbert Constantine, Director of Multiphasic Screening and Chief of Pulmonary Service, Rhode Island Hospital; Associate Professor of Medical Science, Brown Medical School. His topic was "The Relationship of the Community Hospital to its Neighbors", Dr. Constantine related the evolution of developments between RIH and its ghetto neighbors over the last few years. In the discussion that followed, Somerville Hospital representatives expressed a desire to collaborate with RIH as they both proceeded with their programs.

The hospital is planning to continue to develop its new education program and PMI will continue to provide every assistance possible. After a slow beginning, the prognosis is favorable.

Phase IV Contract Evaluation Activities

Introduction

Reflecting the developmental nature of the contract's consultation activities, evaluation activities followed a number of tacts. Thus, evaluation activities included: quantitative tabulations and analyses of services rendered; case studies of each hospital focusing on consultation process and outcomes, as well as mediating factors within the institutions; discussions of hospital-conducted evaluative efforts stimulated by the consultation; and a report of a supplemental attempt to measure shifts in physician attitudes as a result of education.

The current contract is a spin-off of contract NIH 70-4150. Evaluation activities of NIH 70-4150, which examined the impact of PMI's standard educational consultation, a relatively established and stabilized commodity, maximized assessment of its outcomes and minimized examination of its process. Thus, the evaluation design centered on an experimental model utilizing relatively large sample groups (40 experimental and 40 control) to ascertain the extent of "change " caused by the consultation, with little emphasis on assessing its process, i.e., the dynamics of the interaction between consultation and consultee.

As noted in the Phase I section of this report, PMI's standard educational consultation techniques were extensively revised for the current "depressed area" contract (NIH 70-4149). Areas of changes in the consultation model included: the consultant, the consultee, the consultation process and the types of programs stimulated.

Because of the innovative and developmental nature of the consultation procedure in the current contract, a decision was made early in Phase I, with the approval of the contract officer to shift the focus of the evaluation effort to permit a more definitive process study of the workings of the new consultation procedure. On the recommendation of Dr. Donald Kennedy, a cultural anthropologist and Assistant Director of the Center for Community Health and Medical Care of the Harvard University School of Public Health, a scheme was devised in which PMI's research staff and its consultants would serve as "participant-observers" to note and record the process occuring at the consultant-consultee interface as well as consultation outcomes. Consequently, members of the Institute's research staff were present and involved in every phase of contract activities, including all consultation sessions. The data and insight gained through this process is reflected in the preceding "Contract Implementation" section of this report, as well as in the Case Studies that follow.

Services Rendered - Quantified Summary

Before preceeding with the Case Studies it may be helpful to summarize the services rendered to the three contract hospitals. As originally envisioned during the design period in Phase I of the contract, the consultation process would have three essential functions: 1) to get into the hospital and gain its acceptance; 2) to help the hospital gather information regarding needs that existed; and 3) to stimulate development and implementation of relevant education programs. Corresponding to these functions, work with the hospitals was expected to pass in an orderly fashion through three phases: entry, consultation, and program development as diagrammed below.

Consultation Program Development Process

Phases	ENTRY	CONSULTATION	PROGRAM DEVELOPMENT

Figure 1

However, as noted in Phase II and III sections of this report, observation of the consultation process under actual field conditions revealed a more complicated process. Consultation was not the relatively homogenous information gathering, program planning phenomenon we had expected. Instead, circumstances required that consultation take on a variety of roles spanning the whole spectrum of activities indicated in Figure 1 above. First, difficulties in achieving initial entry into two of the three contract hospitals led to the extensive use of consultation inputs in the entry process. Second, the innovative nature of education relevant to poverty or depressed conditions resulted in a need to "educate" key hospital members to the need for this type of education program and program planning. Consequently, consultation assumed an active "teaching" role in addition to its functions in information gathering and program planning. Thus, as observed under field conditions, the theoretically three phase Consultation

Program Development Process actually consisted of four stages reflecting the functions of activities in each stage. The process, as actually observed in operation, is diagrammed below:

Consultation-Program Development Process

Phases	ENTRY	CONSULTATION		PROGRAM DEVELOPMENT
Activity Stages	-Initial Presentations	-Follow-up Consultations to obtain commitment	-Teaching Consultations -Information Gathering and Program Planning Consultations	- Formal Education Programs

Figure 2

The following tables summarize the relative distribution of in-person units of service rendered across the four activity stages in the three contract hospitals,[1] cummulatively and individually.

Table 3

Distribution of Units of Service[2] as a Function of Activity Stages

(Summation of all contract hospitals)

Activity Stage	-Initial Presentations	-Follow-up Consultations to obtain commitment	-Teaching Consultations -Information Gathering and Program Planning Consultations	-Formal Education Programs
Service Units	3	8	9	9

1. Indicated figures do not include services to the Holyoke Model Cities program and area hospitals as discussed in the "Contract Spin - Off Activities" section of this report.

2. One service unit is equated with a consultation-education input averaging two hours (exclusive of travel) by 2-3 consultants. Where inputs varied, multiple or partial units were credited. Recorded service units include only in-person inputs and do not reflect consultations conducted via telephone.

Table 4

Distribution of Units of Service as a Function of Activity Stage

(Rhode Island Hospital)

Activity Stage	-Initial Presentation	-Follow-up Consultations to obtain commitment	-Teaching Consultations -Information Gathering and Program Planning Consultations	-Formal Education Programs
Service Units	1	1	6	7

Table 5

Distribution of Units of Service as a Function of Activity Stage

(Somerville Hospital)

Activity Stage	-Initial Presentations	-Follow-up Consultations to obtain commitment	-Teaching Consultations -Information Gathering and Program Planning Consultations	-Formal Education Programs
Service Units	1	4	2	2

Table 6

Distribution of Units of Service as a Function of Activity Stage

(Hospital A)

Activity Stage	-Initial Presentations	-Follow-up Consultations to obtain commitment	-Teaching Consultations -Information Gathering and Program Planning Consultations	-Formal Education Programs
Service Units	1	3	1	0

Inspection of Table 3 reveals that a total of 29 service units (adding up to approximately 115-175 man-hours of consultation) were delivered to the three contract hospitals. Of the total consultation inputs to the three hospitals approximately 10% were expended on "initial presentations" of the program; 28% went to "follow-up consultations to obtain (the hospitals') commitment (to the program)"; 31% were used for "teaching", "information gathering" and "program planning"; finally, an additional 31% of the inputs were needed in the conduct of "formal education programs." Table 3 also points to where the four-part observed distribution of consultation efforts differed from the theoretically expected three-part process. In order to complete the Entry Phase of Figure 1 eight service units (approximately 30-50 man-hours of consultation) had to be expended beyond the theorectically needed minimum of three "Initial Presentation" service units (or approximately 12-18 man-hours of consultation).

Comparison of Tables 4,5, and 6 suggests that the extra effort required to achieve Entry was not common to all hospitals; that is, it was not simply a case of an across the board underestimation of the effort needed to get into the hospitals and to begin working effectively. Local variables in individual

hospital situations or consultation-hospital interactions would seem to have required the extra work. Potential analyses of these factors (expecially as they relate to the entry problem) are discussed in the individual case studies that follow.

"Services Rendered - Case Studies"

The following case studies depict the interactive process as well as the outcomes of the consultation with each contract hospital. An attempt has been made to differentiate the various roles the consultation played in educating depressed area hospitals to the need for a new approach to continuing education, as well as in planning and implementing the programs. And finally, we have tried to assess those factors in the consultation, the hospital, and the community which tend to aid or inhibit hospital responsiveness to the consultation process.

CASE STUDY I

RHODE ISLAND HOSPITAL

RHODE ISLAND HOSPITAL - A CASE STUDY

Rhode Island Hospital (RIH), a non-profit voluntary general hospital, is a modern 600+ bed institution located in South Providence, an inner city area of Providence, Rhode Island. Employing 3,600 people, RIH is the third largest employer in the state.

In recognition of the current trend toward advocacy of early preventive or curative care on an outpatient basis as a means of reducing expensive hospitalization, RIH began in 1963 to plan for construction of a new multi-million dollar ambulatory patient center (APC). The APC plans, approved by the Trustees in 1968, proposed to improve the "typical outpatient department situation" by devising an appointment system and providing more personalized care through continuity of physicians.

The neighborhood adjacent to the hospital is South Providence, the poorest of the areas comprising the inner city. Some characteristics [1] of its socio-economic conditions are:

1. 50% of its population of 20,000 are Black as compared with 5.3% in Providence as a whole,

2. 8% unemployment as compared to 4.9% in Providence as a whole,

3. 48% of houses are deteriorating and dilapidated as compared to 16.3% in Providence as a whole,

4. a density of 18,780 people per square mile.

As can be expected, there is a high concentration of problems related to the socio-economic environment in this depressed area:

1. The rate of 266.7 illegitimate births per 1,000 live births in South Providence is compared to 61.9 for the city as a whole.

2. The infant mortality rate is 2.5 times greater than the overall rate of non-Inner City Providence.

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1. Data for South Providence: Findings of South Providence Model City Program's study of 1968. Data for Providence 1960 census.

3. The drug addiction rate in the year ending June 20, 1966 was 36.2 known drug addicts per 1,000 males in the 16-29 age group as compared with 6.8 for the city as a whole.

4. In 1966 the area also had the worst record in the city for incidence of venereal disease: the rate per 100,000 was 684 as compared with 302 in the Inner City, and 113 in the rest of Providence.

Furthermore, disease statistics collected by the Rhode Island Department of Health indicate the poor state of health of Inner City residents in relation to the rest of Providence and to the United States. In South Providence, mortality and morbidity rates are even higher than those of the Inner City together. 1

At the same time, there was no concerted attempt to meet the special needs of the poor. Private medical services available were limited to three privately practicing physicians, who did not have admitting privileges at any hospital.

Therefore, the population of the area was almost completely dependent on the outpatient facilities of large hospitals in the area, and on their emergency rooms. The majority of residents had neither a private doctor, nor access to one, did not use any preventive services, and did not use medical facilities other than in crisis situations.

To alleviate this situation, in 1967 Progress for Providence, the city's poverty program, established Neighborhood Health Centers (NHC). There are ten NHC's scattered throughout the Inner City including two in South Providence. These health centers, organized to approximate an office of a private physician, are staffed by internists, pediatricians and obstetrician-gynecologists in such a way that the same physician works in the same NHC on the same day each week. This continuity facilitates forming a lasting doctor-patient relationship. Each NHC is also staffed by a Registered Nurse, and two or three Neighborhood Health Aides who must be residents of the area. Little communication and relationship existed at that time between the hospital and the NHC. The only tangible connection was through a few hospital physicians who did some "moonlighting" at the NHC's.

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1. Selig, Greenberg, "Statistics Show the Need for Clinics in the Slum." Providence Bulletin, February 27, 1968.

Apparently the community was enthusiastic about the centers. Therefore, when the NHC's were threatened with closing in 1968-69 because of lack of funding, the community reacted by confronting RIH with a demand for help. In January 1969 a militant Black community group, supporting the NHC and calling itself the neighborhood's fact-finding committee, confronted the leadership of RIH demanding that the hospital should be responsible for more than just the delivery of health care.

The group leader asked what the hospital had really done for the community. He stated that the hospital by expanding its boundaries was destroying homes in the community. He further related the lack of communication between the hospital and the surrounding community. He felt that people from the hospital just drive in and out of South Providence without knowing and caring about what is going on there.

He also said that the NHC's are the one good thing Progress for Providence had done for the community. He contrasted the dignified and individualized care, i.e., appointment system, continuity in doctor-patient relations of the NHC with the impersonal treatment received in the hospital's OPD.

He further asked the hospital to provide funds to take over Progress for Providence's subsidy of the centers and staff the two clinics in South Providence, while allowing the community to retain control. In addition to granting material support, he called for the establishment of a protective good-neighbor policy, i.e., the black community wanted the hospital to use its influence as an advocate for the community in its dealing with the white establishment. The hospital replied to the demand to subsidize the two NHC's by stating that it was in the "health business" and not in the "funding business".

However, a hospital committee was then established to talk with community representatives. At a later meeting between these two groups, the Black spokesman presented a list of "non-negotiable" demands:

1. One Black should be on the Board of Trustees,

2. The Board of Trustees should meet with the Black community,

3. A list of the hospital's payscale and personnel policies, should be made available.

4. $2,000 per month per NHC (two) should be provided by the hospital,

5. 4-6 hours per week of physician staffing should be provided,

6. More training and recruiting of Black R.N's and L.P.N's,

7. Barbed wire should be taken from the hospital's parking lot fence because it is an insult to the community.

Later, a conference on Health Care in the Urban Ghetto, arranged by Brown University and the Health Department, was held at RIH. During the conference, the hospital was picketed for about two hours by members of SDS from Brown University and later, by people from the neighborhood. Their signs read, for instance, "what has RIH done for South Providence?" "love thy neighbor, support the NHC's".

Following these events, the Board of Trustees of RIH, in March, approved a new policy which supported activities of the Hospital beyond its boundaries, health care for the poor in the surrounding community and involvement in the NHC's. Although this initiative held the potential to close the gaps between the providers and recipients of health care, the policy was not made public, and no immediate action was taken to implement it.

Further negotiations and meetings took place between hospital and community representatives. However, a physician who represented the hospital in these "negotiations" later characterized them to us as holding-actions, saying that hospital representatives did not have authority to effectively respond to these problems and to commit the hospital to appropriate actions.

The hospital finally agreed to supply some tangible property to the NHC's, a refrigerator and medical supplies, as a token of their support. The Black spokesman took some hospital administrators, trustees, physicians and department heads on a tour of South Providence exposing them to the outward signs of slum life, dilapidated houses, heaps of trash and garbage, etc.

At about this time, the PMI consultation team entered the scene. It was both understandable and predictable that RIH would try to utilize PMI's resources to aid in the solution of its immediate problems. PMI resisted being sucked into the tempting role of problem solvers. We stressed that the immediate problems of the hospital were a reflection of a larger set of underlying problems.

In order to help the hospital understand and cope with these underlying problems, PMI saw the necessity of establishing an educational program which would create learning capable of being transferred to problems yet to come.

The Institute's consultants were well aware of the need to initiate the educational process at a point where the learners were, and to start the learning process with the felt problems of the learner. In this case, the learners were feeling great pressure and we had to help them see the need to examine the larger perspective of which their immediate preoccupation was only a part. We cannot stress too fully, the persistence and patience which is required to mobilize the situational anxiety associated with a particular problem, and transform it into the motivation to pursue more generalized educational objectives.

Our goal was to stimulate the development of continuing education programs relevant to the medical problems of the poor and the hospital's relationship to them. At times our consultants endorsed and supported appropriate existing activities initiated by the hospital itself. At other times, we more actively provided leadership and guidance to develop essential educational programs. In the remainder of the case stady we will try to indicate the specific level of our intervention in the various activities that ensued.

Following the hospital's initial response to the militants, a proposal for the establishment of formal relationships between the NHC's and the community hospital was discussed at a NHC Conference. It has been ascertained that NHC's could not function indefinitely as autonomous units. Therefore, discussions were begun with RIH and four smaller hospitals in the city concerning hospital-community relationships. As an outcome of these discussions the following emerged:

1. Patients of the NHC requiring subspecialty consultation were to be seen by appointment at the subspecialty clinic in the neighboring hospital,

2. When more sophisticated lab work and x-ray studies were needed for patients of the NHC, they would be done at the neighboring hospital,

3. Patients of the NHC requiring hospitalization would be hospitalized at the neighboring hospital,

4. The emergency room at the neighboring hospital would provide coverage for patients of the NHC from 9 p.m. to 9 a.m.

As a result of this proposal, the Model Cities Program planned to coordinate medical care between RIH and the two NHC's in South Providence. The administrators of the various hospitals said they would consult the trustees and staff of the hospitals on this matter. Although RIH did not think it could solve all the problems of funding and staffing NHC's and improving the socio-economic conditions in the neighborhood, it saw the need to revise and enlarge its hospital-community relationship.

The director of personnel at RIH seemed determined, once she had the backing from the administration, to hire more people from the community by changing recruitment policies in such a way as to give untrained, but potentially skillful people from the black community, a chance for a job. In this instance, our consultants had merely to support these activities and facilitate spreading information. This new policy entailed the establishment of supplemental training programs in the hospital.

In June and July at the instigation of the director of personnel, sensitivity training sessions were held by a hospital psychologist for 24 out of 50 non-medical department heads. These sessions were geared to develop an understanding of how a well meaning institution like RIH could be viewed as racist by its neighbors. Sensitivity sessions were also planned for primary supervisors to increase their responsiveness in dealing with employees from the surrounding community.

The increased empathy generated by these sessions enabled the hospital to initiate and affect new community-conscious programs. Soon after, other initiatives were forthcoming from the hospital staff. A pediatrician began screening a group of children from South Providence for summer camp. In addition, four RIH physicians began working in NHC's on their own initiative. Within the framework of the Laboratory Education Advancement Program of Brown University, several young men (14-15 years old) from the community have been placed in laboratories of RIH.

The Nursing Department of the Hospital made a special effort to recruit Black candidates for Nursing School by making up credentials and deficiencies, and by giving financial support. The

enrollment of blacks in the Nursing School increased to 19 out of the 91 candiates enrolled. RIH also established a Nursing Assistant Program which did not require a high school diploma. This twelve week course was especially designed to meet the unique problems of young women from the South Providence community.

Furthermore, a Good Neighborhood Program was initiated to meet the urgent needs of the surrounding community. Letters were sent to all employees of the hospital requesting their support in the program and in contributing used clothing, furniture, bicycles and donations.

Our consultation sessions did not provide all the stimuli needed to initiate these programs. But they did provide a forum where ideas could be exchanged and information transmitted between individuals involved in separate responses to a common problem. In many cases, participants reported that these sessions provided the first such communication.

Our early consultation meetings resulted in a solid commitment to the project by the hospital. A plan was adopted which provided for various forms of educational programs which would examine the existing health care delivery system, the problems of this system as viewed by the community and the hospital, the potential areas of change, and the proper relationship and responsibility of the hospital towards the community. Hopefully, such self-examination and criticism would assure the acceptance of its validity and the initiation of corrective measures through either direct action or education. The chances for acceptance of this plan was maximized because the hospital staff itself articulated the need for greater responsibility for the surrounding community and for improved hospital-community relations. It was also hoped that the hospital, in such educational endeavors, would not limit itself to short-term temporary education programming. Apropos attaining the goal of education for self reliance, PMI stressed the need to constantly re-evaluate existing structures, functions and relationships and to adapt to new problems.

Since the concepts of community medicine in general, and NHC's in particular are still new, there was great uncertainty concerning the feasibility of these decentralized medical facilities and the inherent shift in the decision making power to the community. By this time, the consultants were aware that a few individuals in the hospital possessed a great deal of pertinent experience and information, that more individuals had a little pertinent knowledge,

and that still more barely recognized the issues. Therefore, the consultants recommended convening a hospital-wide education forum where key individuals could share and explore their perceptions, and thereby, create a basis for disseminating their collective insights to the rest of the staff. Since those who will have to accept, authorize, or carry out change should be included in the process leading to recommendation of the needed change, we broadened the base of our consultation to include those who could potentially take action as well as those who provide insights.

The format of the forum, entitled Seminar on Community Health, included the participation of representatives of the hospital's board of trustees, administration, allied health and non-medical departments as well as medical staffs. The hospital and PMI viewed the inclusion of these participants as a significant and innovative approach to the development of relevant continuing physician education. The participants were invited by the executive director of the hospital to attend two formal, two-hour working sessions, and an informal discussion over dinner. A slide show was presented during dinner depicting the living conditions in the slums abutting the hospital. Both types of interaction provided a unique opportunity for mutual exchange of views among people who normally have little communication with each other. Our consultants were presented as resource people to aid the deliberations of the seminar.

The full proceedings of the seminar are included in Appendix D. Highlights of the discussion are summarized below.

The executive director of the hospital gave an historical account of the evolution of the hospital's relationship to the residents of the neighboring community including a list of demands that would require a re-evaluation of the hospital's definition of its relationship to the community. The events included picketing, confrontations, repeated negotiations and extended deliberations which led to the hospital's current reconsideration of its proper role and relationship to the community.

The directors of personnel and public relations, psychology, nursing, ambulatory services, and a hospital physician working in a Neighborhood Health Center were subsequently called upon to present their varying perceptions, analyses and opinions regarding the hospital-community situation and the hospital's responsibility for the improvement of health care and health related socio-economic problems in the neighboring area. These presentations

spurred vivid, sometimes heated dicussions which focused on the following issues:

1. Definition of the needs and wants of the community,

2. How the hospital is viewed through Black eyes,

3. What responsibility the hospital has or should assume,

4. Suggestions towards a solution.

One physician thought that since the community does not know how to make demands, the problems, such as housing conditions, become disastrous. Another physician felt that since they don't know how to get medical services, the hospital should help them in that respect.

There was a plea to view the needs of South Providence as the South Providence community sees them. It was noted that from this perspective the new Ambulatory Patient Center would not fulfill the health needs, and therefore, probably would not be used by the community. This center would neither establish the needed continuity in doctor-patient relations, nor meet the desire of the community to be in control of the services. Since there are only a few family doctors practicing in the area, the need for the individualized services they provide can probably only be met in NHC's. These centers are anxious to provide the needed personalized care and continuity in the doctor-patient relationship. It was pointed out several times, that the community does not particularly like the treatment received in the hospital's OPD where the only Black face they see is one of the floor sweepers and fellow patients.

The Director of Ambulatory Services would not accept the notion that the community rejected the OPD. He thought that people coming to the OPD receive the best services possible under the circumstances of ever increasing costs, rising socio-economic, emotional and behavioral problems, and inadequate staff.

A physician working in a NHC pointed out that NHC's not only educate and motivate people to use the available medical facilities, but also promote useful career development programs. Another important function of the NHC's which is linked with the concept of control is developing and instilling pride in the people of the community. Even at the risk of making a mistake, the decision making process is left to the recipients.

As the director of personnel pointed out, RIH is called racist by the community. One of the reasons is that although the hospital is the third largest employer in Rhode Island, it only employs 200 people from the community. She said that it may be a shock to many white employees to hear the hospital called racist, but prejudice must be recognized before steps can be taken towards a solution to the problems. At that point the director of the dental clinic said that "it hurts to hear that these folks don't feel at home because the doctors are white". He felt that the problem had been exaggerated because he had never heard any complaints and had never seen any RIH personnel show signs of racism. He further stated that although NHC's are great for socio-economic cure, they don't have the manpower to care for the health of the nation. Another physician challenged this assertion by asking how many Black physicians are chiefs of service. He said that there are none, and that is what racism means. He was supported by another physician who said he had witnessed prejudice, and recounted discussions among the staff concerning whether they could allow the first Black resident in RIH to do a pelvic on a white patient.

Related to the problem of racism, the question of medical standards was brought up. The physician who had pointed to the fact that not a single chief of service is Black, was asked if he thought that the standards set up for health care in the hospital are too high. He responded "no". As viewed by the Blacks, there are not enough Negro physicians, not enough Negro students in medical or nursing schools, because they are not qualified, qualified by middle class standards.

The staff asked whether the solution to this is to lower standards. Some then asked if lower standards would mean poorer service for the very people who were demanding that the standards be lowered. The physician stated that the community believed that even with lower standards of service, they will be better off than they are now because they are getting zero.

The question was raised of how much responsibility should and could the hospital assume? Can the hospital limit its concern only to the medical problems prevailing in South Providence, without attacking the socio-economic root of the problem? Some people at the seminar thought that there were other social agencies that should be called upon for non-medical problems, such as cleaning up and improving the housing conditions. Another physician

disagreed, and urged the hospital not to view things too narrowly. RIH should begin to help the community out of its present muddle. He felt that if institutions such as RIH do not step in, then the government will fill the gap. This alternative would threaten the medical system with direct government control.

A much debated issue was the possible financial commitment on the part of RIH to fund two NHC's. The chief administrator thought that the hospital was still a long way away from assuming responsibility for even one Center. He said finances are not the issue since Model City is financing the two South Providence health centers. It is rather an organizational problem of coordinating OPD, emergency room and the NHC's services.

A PMI consultant suggested that if the hospital is unable to make financial commitments, it should use its resources to bring in government money to mobilize the community to deal with their problems in a better fashion.

A hospital physician charged that one could expect RIH, an institution with 400 staff members, to go beyond two centers, and to attack the problem in large scale. Others cautioned to tackle the problem step by step without going presently beyond the two centers.

While some participants felt that the hospital was dealing with an emergency situation, and thus it had the task to put out the fire, others felt the hospital should demonstrate to other hospitals and agencies an approach away from the concept of putting out fires, and genuinely become concerned and involved in all aspects of life in the community. They felt that the problem was not an emergency situation, but a continuous cycle. Since new solutions would create new problems, the hospital must expect constant pressure and not immediate credit.

Some projects aimed at an improvement of the relationship between the hospital and South Providence community were reported as already under way, or planned for the near future, i.e., changes in the hiring policy, sensitivity training sessions for supervisors, training of more Blacks for nursing, a twelve week nursing assistants training program, and a Good Neighborhood program. Many suggestions concerning the hospital-community relationship were discussed.

There was a suggestion made by a PMI consultant to help the community organize better to facilitate negotiations with the hospital. A PMI consultant urged the hospital to set up a group that could effectively and continuously deal with the community's problems and build communication networks. The chief of the hospital staff suggested that such an organizational set-up should also include community residents.

Another proposal, coming mostly from RIH physicians presently practicing in NHC's, was to actually staff the centers. One physician said he was sure that out of the large staff of RIH enough interested doctors could be found to practice some hours per week in NHC's. He also urged the hospital administration to help the NHC's with their administrative problems. The President of House Staff agreed by saying that many residents would like to practice in NHC's, feeling that it would be profitable to their education.

Both the immediate verbalizations of the seminar's participants and their later written evaluations pointed to the educational value of the seminar. The latter came from a survey conducted, at the suggestion of PMI, by the hospital administration to evaluate the participants' reactions to the seminar. The hospital's report of its evaluation of the seminar may be found on page 72 of Phase IV of this report.

The seminar's impact may be considered impressive also as viewed from the perspective of ensuing events. Thus, after the seminar, the President of the Staff sent out letters to all physicians in the hospital stating that the hospital had recognized the need to extend the boundaries of its responsibility and commitment to help meet the physician needs in newly evolving health care delivery systems. He then urged the service chief to hold discussions within their respective services of problems and needs such as those articulated in the seminar. A number of such discussion meetings took place and six months later the NHC's reported that staffing their clinics was no longer a problem.

This observed diffusion phenomenon, i.e., a spreading of ideas generated by a limited group to the rest of the staff, evidences the feasibility and utility of PMI's fundamental education-consultation strategy: limited resources can be best utilized in a catalytic fashion to stimulate others towards self-education.

Another outcome of the seminar is that the hospital is now

directly providing a small amount of equipment to health centers and is also providing indirect aid by allowing the centers to purchase supplies through the hospital at its discount rates. Furthermore, the transfer of records between hospital and NHC's is being speeded-up.

A further consultation meeting resulted in a plan to invite several nationally known authorities in the field of community-oriented health care to the hospital to relate their concrete experiences and problems encountered in their work with innovative health care delivery systems in depressed areas. These plans were carried through when the late Dr. E. Richard Weinerman was invited for consultation and educational activities at Rhode Island Hospital on Friday, January 30.

During a day-long visit, Dr. Weinerman had opportunity to become familiar with the RIH community situation, to inspect the hospital and neighborhood facilities in relation to his own ambulatory care experiences at Yale-New Haven, and to make recommendations. In the evening a reception and dinner meeting was held at the University Club in Providence for an invited group of 40-50 people, including medical staff, allied health, and administrative leadership as well as trustees. Dr. Weinerman made specific recommendations. He urged RIH not to consider the "ambulatory care problem" in isolation from the hospital-community complex of needs and health care. He advocated a community-based system of primary care as a foundation for the hospital's specialty oriented ambulatory care clinics, and told RIH to consider assuming partial responsibility for the establishment and maintenance of an overall system of health care for its neighboring community.

The fact that only one planning and consultation meeting between the hospital and PMI team preceeded this second major education program as compared to many such meetings for the July seminar, and that most details of Dr. Winerman's stay were worked out by the hospital team gives evidence of the success of the non-dependency principle, and the principle of maximizing the consultee's involvement.

The educational value of the day Dr. Weinerman spent with RIH was acknowledged by the program's planners when they indicated that additional individuals will be invited for similar educational programs.

RIH has begun to help PMI with its work with other hospitals. Dr. Herbert Constantine, the RIH liaison physician to PMI during the

contract, spoke to Somerville Hospital on October 30, 1970, regarding the relationship of the community hospital to its neighbors. He shared some of the problems, responses and outcomes of the confrontations between the hospital personnel and the ghetto residents. The Somerville Hospital liaison physician indicated that he hoped the two hospitals would continue to cooperate in the future.

Finally, the hospital has just announced the establishment of a new Ambulatory Care and Community Medicine Department. The chairman of the new department, who was involved with the earliest haphazard negotiations with the community, indicated that the establishment of effective mechanisms for responding to community-related needs and problems was one of the most significant developments during the course of our work with the hospital.

In retrospect, the willingness of this hospital to re-evaluate the problems concerning its relationship to the surrounding ghetto area, in the face of community pressure, and to take the necessary steps to meet these needs was essential to the success of our consultation strategy. Facilitating such openness may be a necessary prerequisite for the success of similar efforts at other institutions.

CASE STUDY II

HOSPITAL A

HOSPITAL A - A CASE STUDY

Hospital A (H-A) with two hundred and fifty beds and a staff of 160 physicians, active, courtesy and consulting, is much smaller than Rhode Island Hospital (RIH). In contrast to the urban ghetto conditions surrounding RIH, H-A is located on a hill on the edge of an economically declining former "mill town" about an hour drive from Boston. The depressed community differs in composition from that of South Providence: it is predominantly white with a sizable Spanish speaking population, 5.3% unemployment, 15% of the houses are in deteriorating and dilapidated condition, and population density of 6,467 people per square mile. The target community is not adjacent to the hospital location, but is included in the H-A service area. There are two other hospitals in the city, both church run. The relationship between the three hospitals was characterized by a H-A-PMI liaison physician as "competitive" and "non-cooperative."

When PMI initiated contact with Hospital A, the hospital's activities with the community consisted mainly of supporting three types of community clinics - cancer detection, well-baby and dental. However, as later became apparent, the hospital's involvement emerged as fragmented, and not entirely altruistic to the extent that one spokesmen indicated that the hospital's efforts were, in part, conducted to yield service levels high enough to maintain grants. Furthermore, participation by staff members had dwindled to only two or three physicians who were donating their time.

On April 17, 1969 3 PMI staff members met with the Medical Education Committee of H-A the President of the medical staff of the Hospital, the Administrative Director and 5 other physicians to introduce and discuss the poverty project.

As with the other hospitals, we offered to provide consultative support to help the medical staff identify the health care needs of the poor and plan relevant continuing education programs. Again, the PMI team made it quite clear that their purpose was not to define the problems, or in any way to dictate what should be accomplished, but to help sensitize physicians to the needs of the surrounding community.

The PMI team was greeted warmly at this presentation meeting.

The President of H-A medical staff seemed to quickly perceive what PMI was "selling". He immediately recognized the need to obtain from the medical staff, trustees and administration a commitment of concern and involvement with the poor people the area.

It was suggested that the Executive Committee of the medical staff discuss this matter further at its next meeting, and then respond to our invitation.

On April 28, word was obtained that the staff had voted to:

> "accept the support of the Postgraduate Medical Institute and its staff in its attempt to assess the community health needs, particularly with reference to the disadvantaged populations of . . ."

In June, word was received that the President of H-A had decided to become the liaison physician for PMI-H-A medical staff relations. In sum then, while Hospital A was not seeking help as actively as Rhode Island Hospital, they seemed receptive.

On June 17, a meeting took place between three PMI staff members,one PMI consultant and the hospital's liaison physician and director. The consultation produced agreement that the next step for the project at H-A was to develop a meeting similar to the perception-sharing forum, then in planning at Rhode Island Hospital. The preliminary plan called for a luncheon meeting with the Executive Committee, Trustees, and physicians from the outpatient departments. The meeting, projected for the fall, was to focus on "consideration of the hospital's role in the community". The hospital's representatives were not yet prepared to accept PMI's suggestion that community social work, OEO, etc., representatives also be invited to participate.

On August 13, two staff members of PMI paid a visit to H-A on request of the Director of the Hospital. He requested consultation concerning ways to stimulate local resident's participation in neighborhood health facilities to which the Hospital contributed. The visit involved a site trip to one of the clinics. The PMI staff made recommendations, and also used the opportunity to further discuss the upcoming seminar. The Hospital's Director now expressed interest in also including community residents (consumers) in the seminar.

Following this contact, several additional proddings by PMI

aimed at finalizing plans and schedules for the seminar failed to produce the desired results. The delay seemed to reflect a degree of insecurity on the part of the Hospital regarding their ability to successfully introduce and implement this new type of education (both content and format). PMI thought however, that with some coaxing and support, the Hospital would eventually move ahead towards the goal.

More communications took place by mail and telephone between the Director of H-A and PMI. However, it was not possible to bring about the meeting with the executive committee, trustees, and physicians from the outpatient departments that had originally been planned. The Director of the Hospital now seemed reluctant to hold the seminar without full assurance of the staff's interest. The liaison physician now also seemed reluctant. According to him only about 30% of the staff, namely those who were also involved in the group practice headed by the liaison physician, seemed particularly attuned to and interested in the problems of people in depressed areas. The liaison physician characterized his group as the "progressive element" of the staff.

In a renewed attempt to bring about a commitment to an educational activity, Dr. Stearns outlined some potential steps. He suggested that the hospital:

1. Compile a list of people who have some knowledge of the problems of medical care for the poor the area, and who can relate to others what is going on in the community. This list might include M.D.'s, R.N.'s, social workers, administrators, OEO, health departments, community representatives, etc.

2. Compile a list of those who should be familiarized with the various multiple aspects of the problems and stimulated to become more involved and make more concerted efforts (e.g., trustees, those who are listed above, representatives of the medical staff, executive committee, and others).

3. Arrange for these two groups to meet together for the purpose of presenting and sharing information, knowledge,etc. (if desired, in the presence of outside resource people such as community health care specialists (PMI consultants) or the Rhode Island Hospital liaison physician). Objectives of the meeting should be to plan one or several next steps and to consider such questions as:

   a. Should there be a planning council of M.D.'s and other representatives?

b. Should outside experts be brought in?

c. Are there known specific medical problems in the poor community that warrant specific medical educational sessions, e.g., T.B., V.D., malnutrition?

d. Is it reasonable to do nothing new or nothing more?

e. Should attempts be made to involve more people or should the situation be left where it is now with only a few persons involved (by self-selection)?

The liaison physician's answer to these suggestions was that in his view, it is hopeless to try to get the staff at large involved. He said that only members of the group practice come to meetings concerning health care services to the poor; only they are willing to do things such as work in the community clinics; the rest of the staff is not interested in this complex problem. He promised however, to bring Dr. Stearns' proposals up at the next staff meeting.

Dr. Stearns pointed out that it need not be the immediate (or even ultimate) aim of the educational program as such to get the staff to man the clinics, but that PMI would like to first have an opportunity to improve awareness and to introduce a new approach to the examination of the medical needs of poor people.

On January 24, the liaison physician of H-A sent PMI a letter reporting the outcome of his hospital's staff meeting indicated above. The body of his letter is quoted below:

"Several days after our last conversation, I presented the background of the previous meetings and asked for people who had attended those meetings to speak on the subject, and at that point, at our annual meeting of the staff which had an approximately 95% attendance and asked for a vote. I am extremely sorry to say that my original estimate thought to be a very low one by you, proved to be a disappointment to both of us, for out of the entire staff of Hospital A, only six doctors indicated that they had any interest in participation even to the extent of encouraging any, and of these six, four were already involved in our out-reach

clinics and I am not certain that one of the others really heard the question.

The Director has definitely been interested in the needs of the community and I think some of us have some quite workable ideas about what the community needs, but we have a number of factors that are bothering us and I might list some of them as follow (sic):

1. Total lack of physician interest.
2. Multiplicity of agencies who have no coordinating method.
3. Evanescence of many of these agencies.
4. The competitive non-cooperative long-standing attitudes of three grade A hospitals in one community with a population of less than 90,000.
5. It would be possible to establish a central coordinating agency and to expand the existing "out-reach clinics" to include particularly in relationship to the three hospital out-patients' around the clock service if funding were forthcoming for a reasonable period of time.

I am sorry, but not at all surprised that instead of more interest that there is less interest, for the opinions in this area, at least, are hardening around a statement that we need fewer studies and more work."

Though PMI was prepared to further pursue the development of a working relationship with H-A, building on the problem factors as outlined by the liaison physician, and though the Somerville Hospital also expressed interest in developing some type of coordinated activity with the H-A area hospitals, and offered to assist with their recruitment, we were not able to effect a lasting relationship.

Strained relations within the hospital between members of the large group practice and other members of the staff may have contributed to our failure to obtain a unified commitment to our project. We suspect that our efforts to convince our local advocates of the merits of our program were not strong enough to overcome or cope effectively with the underlying political suituation.

CASE STUDY III

SOMERVILLE HOSPITAL

SOMERVILLE HOSPITAL - A CASE STUDY

Somerville Hospital, the smallest institution in the study has 148 beds and a total medical staff of 134, of which 50 are active members, the others being courtesy or consulting members. It is located in close proximity to major medical centers in Massachusetts. The surrounding community has the highest population density in Massachusetts, 21,967 people per square mile; 14% deteriorating and dilapidated housing; 4.1% unemployment; .4% Black residents; and a relatively low average annual income of $6,024.

Postgraduate Medical Institute (PMI) hoped to initiate deliberations to stimulate Somerville Hospital and its medical staff to identify the community's unique health care problems, its staff's educational needs relating to these problems and some possible solutions. We first tried to recruit the hospital's participation in April 1969. PMI departed from its normal pattern of preliminary consultation with a cross-section of staff leadership as utilized at Rhode Island Hospital and at Hospital A. Instead, at the invitation of the Chief of Medicine, Dr. Stearns made our initial presentation to a full staff meeting. Dr. Stearns was presented as "today's speaker". The staff listened but was unresponsive in sharp contrast to the reactions our initial presentations received at both Rhode Island Hospital and at H-A. Repeated efforts to follow-up this initial presentation were fruitless for a long time. We later found out that our initial approach had only aroused antagonism and defensiveness in the staff. We had been perceived as a threat to the existing education program and the normal decision-making channels.

On June 9, 1969 the liaison physician of Somerville Hospital, the Chief of Medicine, reported to PMI that after consulting with the executive committee, the hospital staff did not think it had enough time to commit itself to the program. Responding to a call by the PMI project director the liaison physician stated that although the staff was not interested at that time, maybe another PMI presentation could be scheduled for the fall.

In September, the liaison physician requested a written outline of the possible programs and approaches to present to the medical staff committee. On October 14, PMI sent them a summary of the intentions of the program, and five possible courses of action. A copy of the proposal is included in Appendix B. PMI hoped that

the outline would provide a focus for the medical staff executive committees' reconsideration of the program.

On December 19, the proposed fall presentation was realized. The hospital administrator and the executive committee met with the PMI consultants to discuss and clarify the purpose of the program and specifically the overview sent to the hospital in October. Apparently the committee had previously discussed the proposal because they asked for additional clarificiations of the activities in which the hospital would be engaged. PMI's executive director then outlined the goals of the contract stressing its flexibility in terms of the types of activities. He further encouraged physicians present to share their individual experiences and insights relative to the problems of their community. The purpose of stimulating this discussion was to illustrate the value of systematically examining the medically related problems of depressed area residents, and to provide a sample educational experience. Thus, for example, the chairman of the executive committee reported the existence of a committee, including two physicians, which was responsible for the problems of the poor in Somerville. It was learned that the committee had no formal connection to, or delegation of responsibility from the medical staff of Somerville Hospital. This information pointed to the need for open discussion among the medical staff regarding the current conditions of the poverty area residents and their relationship to the hospital.

On January 14, the hospital's Medical Education Committee Chairman reported that he had been appointed as chairman of an ad hoc committee to evaluate PMI's proposal. He said that he attributed the negative response to the first presentation at the general staff meeting to a reluctance on the part of the staff to proceed with an educational endeavor that might potentially compete with the hospital's existing continuing education program. He hoped that progress could now be made by funneling the program through the existing continuing education channels which he headed.

The DME indicated that in order to effectively present the project to his hospital he needed a reasonably detailed background of the nature of PMI, its activities and goals, including the details of money, time, and personnel costs to the hospital. After a lengthy discussion, the DME indicated that he had acquired all the background information he had requested. The remainder of the meeting was devoted to consideration of the DME's suggestion

for developing an acceptable model for a program at Somerville Hospital. The agreed-upon goal of the program was to develop staff participation and realization of the needs of people in depressed areas. Progress towards this goal would initially be achieved by the establishment of a staff committee whose objective was to provide opportunities for communication. The proposed committee would be composed of the Chief of Staff, the community Public Health Officer, Chairman of the education committee, the Administrator, a social worker, a nursing representative, and representatives of the departments of medicine, pediatrics, surgery, general practice and obstetrics-gynecology. Additional consideration was given to the potential use of speakers or consultants as either resources to the committee or speakers in a more formal education program. At the conclusion of the meeting the DME indicated that he would present the outlined program, as well as his full conception of the program to the ad hoc committee who would make recommendations to the executive committee regarding the participation of the hospital in the program.

In March 1970, PMI was notified that the executive committee in conjunction with the medical staff voted to accept the recommendation for participation in the project. Thus, after many months of formal and informal negotiations, we were able to go ahead and implement our program.

Educational programs, utilizing nationally known guest speakers experienced in innovative health care delivery systems, were initiated in June of 1970. Dr. Jack Geiger, Professor and Chairman of the Department of Community Health and Social Medicine, Tufts University School of Medicine, addressed the medical staff on the issues in the delivery of primary medical care. The issues discussed focused on physicians who played an integral role in the medical care of the poor in the community.

A second educational program held in October of 1970 revolved around Dr. Herbert Constantine, the Director of Multiphasic Screening and Chief of Pulmonary Service at Rhode Island Hospital; Associate Professor of Medical Science at Brown University; as well as PMI's liaison physician with RIH. He shared his views regarding some of the problems, responses and outcomes of the confrontations between Rhode Island Hospital personnel and its ghetto residents. These educational sessions gave the medical staff of the hospital additional insights into

the problems and responses of other hospitals in depressed areas as they attempted to meet the needs of the community residents.

As was the case at RIH, the consultation-teaching sessions at Somerville Hospital were used 1) directly as teaching activities in that the consultants used them to help the staff see the need for poverty-related education program, and 2) as the procedure for planning the actual programs. However, where RIH created additional education programs using innovative formats, Somerville Hospital planned and implemented education programs within the structure of the existing continuing education program. These programs utilized more traditional educational formats, such as informal lectures followed by discussion.

The more deliberate approach followed by Somerville Hospital is certainly a reflection, if not a consequence, of a lower level of community pressure than that exerted on RIH. Yet, as Dr. Geiger said "it is really important that community hospitals...start to try to take another look, start trying to evaluate their own role in relationship to the problems of delivering health care for the poor. This (Somerville Hospital) is one of the first community hospitals that I know of that is taking this kind of look."

The hospital is prepared to continue its new education program beyond the period of the contract and PMI will continue to assist it. After a slow beginning, the prognosis is favorable.

Consultee-Conducted Evaluation Activities

A fundamental principle of PMI's approach to education is that assessment of its impact should be an essential part of the education process. This principle contains at least three important implications for the program planner.

1) The educational validity of an activity should not be assumed, a priori, in either absolute or relative terms;
2) Evaluation of education should be conducted to determine its value;
3) Assessment of the impact of current educational activities should be an integral part of the planning process for future programs.

In keeping with this principle, the consultant team encouraged the hospitals to conceive and conduct independent assessments of the education programs developed under the contract. Rhode Island Hospital undertook such an evaluation in conjunction with the July 23 hospital-wide "Seminar on Community Health," previously discussed in several sections of this report. A simple nine item check-off questionnaire covered such areas as participant's reactions to the seminar's scheduling, format, materials, composition, and educational value. An open-ended invitation was also extended for more extensive comments and suggestions regarding the seminar and future programs. The systematic rigor of this evaluation and its ability to demonstrate the impact of the seminar beyond the "felt" level are certainly open to question. However, it was designed to produce data pertinent to: 1) assessing the activity's value; and 2) planning future programs. As such, this hospital-planned and conducted evaluation was consistent with the principle and implications with regard to education and evaluation outlined above, which the consultation sought to teach.

The hospital's report of the results of the evaluation, including summarization of responses to the questionnaire and other comments, are reproduced on the following pages:

SEMINAR ON COMMUNITY HEALTH

CRITIQUE

(Thirty-seven participants excluding P.M.I. - thirty-one questionnaires returned)

1) Over and above the heating and noise problems, the facilities and arrangements at the Motel were adequate.

Yes 29 No 2 Qualified Yes ___ Qualified No ___

2) Did you find the background material distributed at the meeting of benefit to you?

Yes 25 No 2 Qualified Yes 3 Qualified No ___

3) What is your opinion as to the size and composition of the group who attended the seminar?

O.K. 9 Too Large 16 Too Small ___ Composition: Good 8

Poor 8

4) Was the day of the week and time of the meeting convenient for you?

Yes 26 No 4 Qualified Yes 1 Qualified No ___

5) Was the time allotted for the meeting adequate and well utilized?

Yes 25 No 1 Qualified Yes 3 Qualified No 1

6) Was the participation of representatives from the Post Graduate Medical Institute beneficial?

Yes 22 No 5 Qualified Yes 2 Qualified No 1

7) Do you feel that the seminar gave you a better understanding of the problems of the community?

Yes 22 No 7 Qualified Yes ___ Qualified No ___

Of the hospital?

Yes 28 No 2 Qualified Yes ___ Qualified No ___

8. Do you feel that further seminars should be held on this subject?

   Yes 30 No 1 Qualified Yes ___ Qualified No ___

9. Would you be willing to participate?

   Yes 28 No ___ Qualified Yes 1 Qualified No ___

SUMMARY OF COMMENTS AND SUGGESTIONS

It was the opinion of many in the group that this original meeting should be followed by many more meetings (in order to continue the momentum). It was felt that the group should be smaller and further break up into "action" groups to deal with very specific problems. There should be participation by members of the South Providence Community.

The PMI people should play more of a leadership role and should formulate specific items for attempted resolution.

Better in-hospital coordination is needed. There is the feeling that too many people and committees are involved with different parts of the problem. It was suggested that we utilize the services of the Brown Sociology Department to obtain information about population groups.

There was the feeling that we are going too slowly and that we need a definitive thrashing out of specific problems and that the Visiting Staff must become more deeply involved in the hospital's problems in this particular area, and that this should be separate and apart from their personal professional problems.

Suggested topics for future and immediate consideration:

1. Specific role and contribution of Rhode Island Hospital.
2. How to communicate with the responsible members of the Community.
   a. To understand what their needs are as they see it.
   b. To understand specifically what they would like of Rhode Island Hospital.
   c. To interpret to them what Rhode Island Hospital can do for them.
3. Interpretation to Rhode Island Hospital staff the unique needs of the community.

Three specific questions relating to hospital participation were raised:

1. To what degree do we lower employment standards for blacks?
2. Can we establish apprentice programs in B & G?
3. Do we integrate health centers into teaching programs (with what impact on currently moonlighting residents and on patients in the Centers?)

The following questions were asked by one participant. How can a loyal employee, who desires to be helpful to his superiors find a way to point out hazards in a program, which seems to have already been decided upon, without appearing to be disloyal, stupid, blind, not compassionate, bigoted, narrow, etc., etc.?

After the articulate academicians had mauled Dr. X, only the bravest of the brave would dare stand before the steamroller.

Do doubtful statements become less doubtful through massive repetition and prestigious pressure?

Attitude Change Study

As stated in the February-April, 1969 Quarterly Progress Report, PMI proposed to expand the scope of the evaluation of the project to also include:

> Identification and characterization of shifts in physician attitudes vis a vis community medicine as well as physician and hospital responsibility in relation to the health care problems of depressed areas.

For this purpose PMI staff envisioned pre and post measurement of said attitudes, with the pre measurement being obtained before the advent of any educational activity, and the post measurement being obtained after completion of all such activities.

Rhode Island Hospital medical staff was selected as the experimental population on which to attempt the attitude study. With approval of the contract officer, PMI opted to support development of the attitude study and the necessary instruments with its own

funds; i.e., with funds other than those received as part of this contract.

The first formal educational session at Rohde Island Hospital was scheduled for July 23. Consequently in June the staff began to elaborate approaches to measurement of attitudes in the context of this project. Short questionnaires or interviews seemed to be the most feasible approaches with such time-pressured subjects. After repeated revisions, two instruments emerged. One, an open-ended 3 question interview, could be administered in person (by a trained interviewer) or by telephone. The other, a questionnaire with 12 check-off items, contained statements to which the doctors would have to put checks in one box of a range of agree to disagree categories for each statement. (See Appendix E.)

PMI had hoped to administer one of the instruments to a randomly selected sample of the Rhode Island Hospital physicians. Ideally, the second instrument would then be given to a second random sample. Thus a comparison of the efficiency of the instruments and some indication of their validities could have been obtained.

Rhode Island Hospital administrators pointed out difficulties associated with trying to obtain a random sample of physicians whose appearances at the Hospital are irregular and at times infrequent. The idea of mailing the questionnaire instrument to a random sample of hospital physicians was also rejected in view of PMI's past experiences with poor and biased returns of mailed questionnaires. The Hospital also would not permit use of the open-ended interview. They felt that such potentially sensitive issues should be dealt with on an in-house basis first.

Therefore, as a compromise to our needs for premeasures, the Hospital agreed to permit administration of the 12 item questionnaire at a series of upcoming grand rounds. Data were obtained from:

17 physicians at pediatrics grand rounds on July 18,
50 physicians at medical grand rounds on July 19,
12 physicians at surgical grand rounds on July 22,
30 participants at the beginning of July 23 seminar.

A form of coded identification was provided so that it would be possible to contact the same individuals for postmeasurement and trace any attitude change by individuals as well as for the groups.

Following an extensive series of educational programs at RIH during the summer, fall (1969) and early winter (1970), PMI began to prepare the post measurement component of the attitude survey.

At the same time negotiations were initiated with the hospital regarding its implementation. The Hospital at first asked for a delay in the implementation of the survey and, ultimately, rescinded permission entirely.

In what turned out to be an ironic twist of fate the attitude survey was doomed, at least in part, by the success of the consultation in bringing about major changes at RIH. As the hospital and its medical staff moved closer to accepting a new role with respect to their responsibility for the surrounding depressed area community, they (those administrators and physicians acting as the internal change agents with whom we were working) become increasingly apprehensive of anything (such as our survey) which might upset the delicate internal political process that was necessary to gain staff-wide approval of things such as support for the neighborhood health centers or a new department of Community Medicine and Ambulatory Care. While inconvenient to us, the concerns of the change agents in the hospital were quite understandable.

Too much time and far too many variables had intervened by the time any further consideration could be given to implementing the post-measurement survey. However, the consultation team took consolation from the fact that its surveying efforts were impeded not by a lack of attitude change in the consultees but by the very imperatives of a successful change process.

CONTRACT CONCLUSION

CONTRACT CONCLUSION

Postgraduate Medical Institute believes it possible to use an interdisciplinary team of consultants to sensitize hospital medical staffs to the unique health care problems of the poor.

In recent years there have been exciting developments in the delivery of health care. The literature is rife with reports of experiences and new ideas regarding health care delivery. These proposals, encompassing neighborhood health centers, group practices, pre-paid comprehensive health care systems, HMO's etc., have a common, distinguishing characteristic--CHANGE. They all imply major changes in the conduct of the practice and "business" of medicine. The prospect of change is often threatening. We fear that the agents of change, the activists developing new systems, may fail to divert energies needed to help the medical establishment accept the changes. For most, re-education will be needed, and for many the experience will be painful. Change can be brought about by legislation and rationalization or by education and insight. Postgraduate Medical Institute prefers the carrot of insight to the stick of law, though we recognize that a judicious application of both may be needed to effect changes in the complex health care field. We believe that education, in combination with professional, social or legislative pressure, can help to close some of the gaps between physicians developing new health care systems and those resisting them.

The Postgraduate Medical Institute (PMI) is the education arm of the Massachusetts Medical Society. Since its inception eighteen years ago, the Institute has been dedicated to fostering continuing education of physicians. Its operations are predicated on the premise that education can ultimately effect improved health care.

For many years we have been using consultation as a stimulus to education program development at community hospitals. In a recent three-year study* of the consultation process, we attempted to help forty hospitals assess their needs and develop relevant programs. Results of the study demonstrated that intervention by physicians trained as educational consultants significantly affected implementation of elements of continuing education programs for physicians. However, most educational activities stimulated were of the classic variety and dealt with familiar areas of medical practice, e.g., grand rounds on "Hypertension", or lectures on "Leukemia".

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*NIH 70-4150 (PH-108-67-170)

While this study was in progress, health care consumers in depressed areas were increasingly challenging the medical profession's expertise, responsiveness and right to define proper health care. Consequently, the Public Health Service funded PMI to modify and study its consultation techniques when used to stimulate medical staffs of three hospitals to: 1) recognize the special health needs of the poor in their communities; and 2) develop responsive physicians' education and service programs. This report has described the consultation model that was developed and discussed what was learned while trying to apply the procedure.

Both the consultation model and conclusions derived from the application and evaluation of it are summarized here. We thought it important to emphasize the interlocking nature of medical, socio-economic, psychological and cultural aspects of health care problems of depressed area residents and their hospitals. Therefore, the logical direction was to abandon our exclusively physician-oriented consultative focus. In its stead we substituted an interdisciplinary team of consultants. The team consisted of two physicians, a cultural anthropologist, a psychologist, a public health educator and supporting evaluation personnel, used in varying combinations. The team collectively possessed expertise in medical education, community medicine, health care delivery systems, as well as educational and evaluation methodology.

Extending the team concept, we envisioned working with a "corresponding" interdisciplinary team of hospital personnel led by members of the medical staff and including representatives of allied health and administrative staffs, as well as trustees.

Our intent was to have the two teams examine the depressed area community and the hospital's relationship to it as a "patient", with the health care problems of such a "patient" the subject of discussion. Thus, in addition to its function as an educational catalyst, the consultation procedure itself was to serve as an educational activity.

An early objective of consultation was to create an atmosphere conducive to frank and open discussion. Data regarding the community and its problems was obviously needed, but consultants felt that hospital personnel might react defensively if confronted initially by community representatives. While expecting that the issue of the need for community involvement would become manifest eventually, we thought it imperative that impetus to promote such involvement come from the hospital representatives. Therefore, during initial discussions consultants refrained from suggesting direct involvement of community representatives in the consultation process.

To implement and evaluate the consultation process, three dissimilar target hospitals were selected: 1) a large, urban institution in the midst of a black ghetto; 2) a smaller institution in a predominantly low income, white community of high population density; and 3) an institution on the fringe of an economically declining, medium-sized former "mill town" possessing a significant Spanish speaking population.

Specific details of what happened when consultation was implemented and evaluated have constituted the body of this report. At this point some broader generalizations and implications of our findings would seem appropriate. We feel our approach embraces four central concepts of the American Medical Association's program to improve health services for the poor, adopted by the AMA House of Delegates at the 23rd Clinical Convention held in Denver, November 1969:

> 1) It is a basic right of every citizen to have available to him adequate health care...and the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person.
>
> 2) The medical profession must take the leadership and actively support constructive community efforts to eliminate those conditions that adversely affect health.
>
> 3) The health problems of the poor are basically community health problems, and since a national health program will not solve all of them, programs must be adapted to local needs.
>
> 4) Health care to the poor should not be disassociated from, but rather should be a vital part of, the overall health care system.

Successful implementation of action programs, such as that of the American Medical Association, will require involvement of major segments of the profession. Our experience indicates that the AMA still has a major task ahead of it to promote acceptance of the concepts of its action program by state and district societies, and to effect their implementation by medical staffs of community hospitals. Techniques to stimulate physician and medical staff involvement will be needed. We feel the approach described is such a technique. However, as reported, one of the hospitals in the

study was more responsive to educational consultation than the other two. The variations in response may be attributable, in part, to internal differences; e.g., differences in hospital size, sophistication or resources. However, one of the most important variables may reside outside the hospitals. This is the variable of external pressures for change, be they of community, professional, or legislative origin. The large urban hospital received a loud, clear message of the need for change from its confrontation with militant blacks in the neighborhood. With the hospital's inertia overcome by the community's "stick", educational consultation was able to focus the hospital's response in the direction of self-examination and rational consideration of the problems. The other two hospitals experienced little pressure from their communities and, thus, to consultation fell the additional task of establishing even an awareness that there might be problems to consider. Consultation was able to accomplish this in one of the two situations cited.

While educational consultation may be less efficient in the absence of a "stick", our experiences indicate that consultation may be an effective mechanism to facilitate constructive change at a time when medicine is being confronted by an increasing number of societal pressures. A yet more desirable or effective pressure could come from a renewed, stronger effort by the AMA to implement its 1969 poverty program.

In summary, the model of consultation that PMI has used to stimulate hospital medical staff involvement in health problems of the poor may be characterized by the following principles:

1) Educational consultation is provided by an interdisciplinary team;
2) Consultation is used both as a catalyst and as an educational activity itself;
3) Consultation stresses critical self-examination as an avenue to insights and corrective measures;
4) Consultation seeks participation of individuals who will authorize, effect, and ultimately accept change;
5) Consultation starts with felt problems and seeks to motivate long-range planning;
6) The approach seeks to maximize consultee involvement in program planning;
7) Consultation tries to use educational mechanisms that will assure diffusion of its effects to the staff at large; and
8) Consultation seeks to minimize the formation of dependency relationships.

In spite of difficulties cited, educational consultation can be a useful technique to bridge knowledge, service and information gaps between innovative activists developing new health care delivery systems and the majority of hospital medical staffs which are, as yet, uninvolved. But we cannot overstress the effort, persistence, diplomacy and patience needed to translate philosophical positions and paper proposals into real and meaningful improvements in the health care delivery system.

CONTRACT SPIN-OFF ACTIVITIES

CONTRACT SPIN-OFF ACTIVITIES

In addition to pursuing activities with the three hospitals specified in the contract, PMI also provided consultative service to a fourth "unit" as described below.

In November of 1969, PMI was contacted by Dr. Robert Abrams, a physician from Holyoke, Massachusetts, who was in charge of working up the health care component of the application for a Model Cities grant for a depressed area in that community. He indicated that he had heard of PMI's work in poverty areas, and requested an opportunity to review his ideas and receive consultation.

A series of consultations, held in both Boston and Holyoke, revealed that the Model Cities health planners were proceeding without any concrete plan to promote the involvement of physicians from the area's two hospitals, or to facilitate integration of the services of the proposed Model Cities area clinic with those of the hospitals. Consequently, drawing on our experiences with the Rhode Island Hospital-Neighborhood Health Center problems, we made several recommendations to the Model Cities planners. Specifically, we urged that they formally involve the medical staffs of the two area hospitals in the Model Cities program as soon as possible. As noted in the December 1969 Hampden Hippocrat[1] and in personal communications, PMI's recommendations were endorsed and implemented by the Model Cities Health Task Froce and the two area hospitals.

In another response to our initial recommendations, our consulting team was invited to the Holyoke Hospital. A portion of one of the consultants field reports is quoted below to illustrate the tact the consultation took in an attempt to stimulate physician-led hospital involvement.

> We were invited by Dr. Robert Abrams, a Holyoke Pediatrician who has been an active leader in developing health components of Holyoke's Model Cities Program, to visit the Holyoke Hospital for the purpose of exploring the possibity of PMI's offering assistance (similar to that extended to the Rhode Island Hospital through the

1. Robert M. Abrams, M.D., Holyoke's Model Cities Health Care Program. Hampden Hippocrat XXXV:17-19, December 1969.

Poverty Project) in the development of the health component of their Model Cities Program. Earlier it had been suggested by PMI that Dr. Abrams form a committee comprised of physicians from both of the hospitals in Holyoke and this meeting was billed as a meeting of that joint committee. However, at PMI's suggestion in addition to physicians there were also a number of public health nurses, the Director of the City Health Department, Chairman of the Health Task Force of the Holyoke Model Cities Program, and several other community representatives. Dr. Stearns briefly described PMI and its previous experience in the Poverty Program. He commended the health leadership of Holyoke for the progressive planning already accomplished. It soon became evident, however, during the course of the discussion which Dr. Stearns led that not everyone present was fully aware of their respective roles vis-a-vis public health in Holyoke or the health services component of Model Cities. Dr. Abrams was asked to define the efforts of the Health Task Force to date and the role of physicians in the hospitals in relation to it. Several people observed that efforts should be made to coordinate more closely the many facets of health services being offered to the "poor".

At a later stage in the development of the health clinic, we were asked to provide assistance with the following organizational and procedural questions related to the establishment and management of the clinic.

1. We're setting up a non-profit corporation to run the clinic. Are there any established formats for this?
2. What are the salary arrangements made with the clinic staff and what are the pay scale guidelines?
3. Since we are a government sponsored program, can we collect from Medicaid?
4. How do we collect from Medicaid-Medicare through the corporation?
5. What transportation arrangements have been made to get patients to and from the clinic and from the clinic to the hospital or Doctor's office?

6. What have been the most satisfactory hours for the clinics?
7. What arrangements have been made for specialty clinics to be held at the neighborhood centers? How are they run, organized, and financed?
8. How have large-scale screenings been organized (for lead poisoning, serum profile, paricites, etc.) What is the best way?
9. How are priorities decided upon, i.e., what kinds of services, how much?
10. What ways have para medical people been used (outreach follow-up, etc.)."

In this instance we did not directly provide answers or recommendations. Instead, we functioned in a liaison role, providing the Model Cities Program with access to appropriate technical resources.

In a recent personal communication, Dr. Abrams, now Vice President of the Model Cities Health Task Force, noted:

> The Holyoke Model Cities Health Clinic has now been in operation for two weeks. We are operating out of a store front now, but will be moving into a newly constructed health facility in five months.
>
> There has been very active local physician participation with eight local doctors working part time in the store front clinic and with guide lines for running the clinic having been drawn up by several subcommittees composed of Hoyloke physicians who are familiar with the local situation.
>
> The clinic in this inner city area of Holyoke has the potential of fulfilling a great need. We have come to realize the wisdom of your suggestion that local physicians become intimately involved and become partners in this venture of providing better medical care for the indigent. The meetings that we had with you and your associates in Boston and Holyoke had a definite influence on our getting on to the right track, so to speak. In the near future, we hope to call on the PMI staff for a critique in the running of the clinic.

We anticipate continued development of our consultative and educational relationship with the Holyoke Model Cities Program and the city's two hospitals.

CONTRACT DISSEMINATION

CONTRACT DISSEMINATION

The following is a chronological listing of Postgraduate Medical Institute publications, papers and formal presentations pertaining to the contract, its design, procedures, outcomes or concepts.

"Program Motivation and Stimulation - The Activities of the Postgraduate Medical Institute", Norman S. Stearns, presented at Conference on Goals and Techniques of Continuing Education, sponsored by the Association for Hospital Medical Education, February 4-5, 1970, Chicago, Illinois.

Interdisciplinary Team Consultation - An Educational Device to Promote Hospital Staff Involvement in Problems of the Poor. Stearns, Norman S., and Gold, Robert A. Clinical Research, 18:481, April, 1970.

Postgraduate Medical Institute: Its Challenging Role in the Continuing Education of Physicians and Other Health Care Personnel, Robert P. McCombs, M.D., Massachusetts Physician, June, 1970, 34.

"The Postgraduate Medical Institute in Continuing Medical Education", Norman S. Stearns, presented at Conference on Continuing Medical Education, sponsored by American Medical Association, October 13-15, 1970, Chicago, Illinois.

"Educational Consultation: A Team Approach to Stimulating Hospital Medical Staff Involvement in Health Care Problems of the Poor.", Norman S. Stearns and Robert A. Gold, presented at the Medical Services Conference, sponsored by the Council on Medical Service, American Medical Association, November 28, 1970, Boston, Massachusetts.

"A Continuing Medical Education Agency: Postgraduate Medical Institute", in Continuing Medical Education in Community Hospitals: A Manual for Program Development. Norman Stearns, Marjorie Getchell, and Robert Gold, Massachusetts Medical Society. Boston: 1971 (Published as a supplement to the New England Journal of Medicine, Volume 284; Number 20; May 20, 1971.)

Educational Consultation: A Team Approach to Stimulating Hospital Medical Staff Involvement in Health Care Problems of the Poor, Norman S. Stearns and Robert A. Gold, Medical Care, Volume 10; Number 1, January-February, 1972. (accepted for publication)

In addition to PMI publications, papers and formal presentations, the following published citations or reports of the contract have also appeared.

Holyoke's Model Cities' Health Care Program, Robert M. Abrams, Hampden Hippocrat, Volume XXV; Number 10, December, 1969, 17-19.

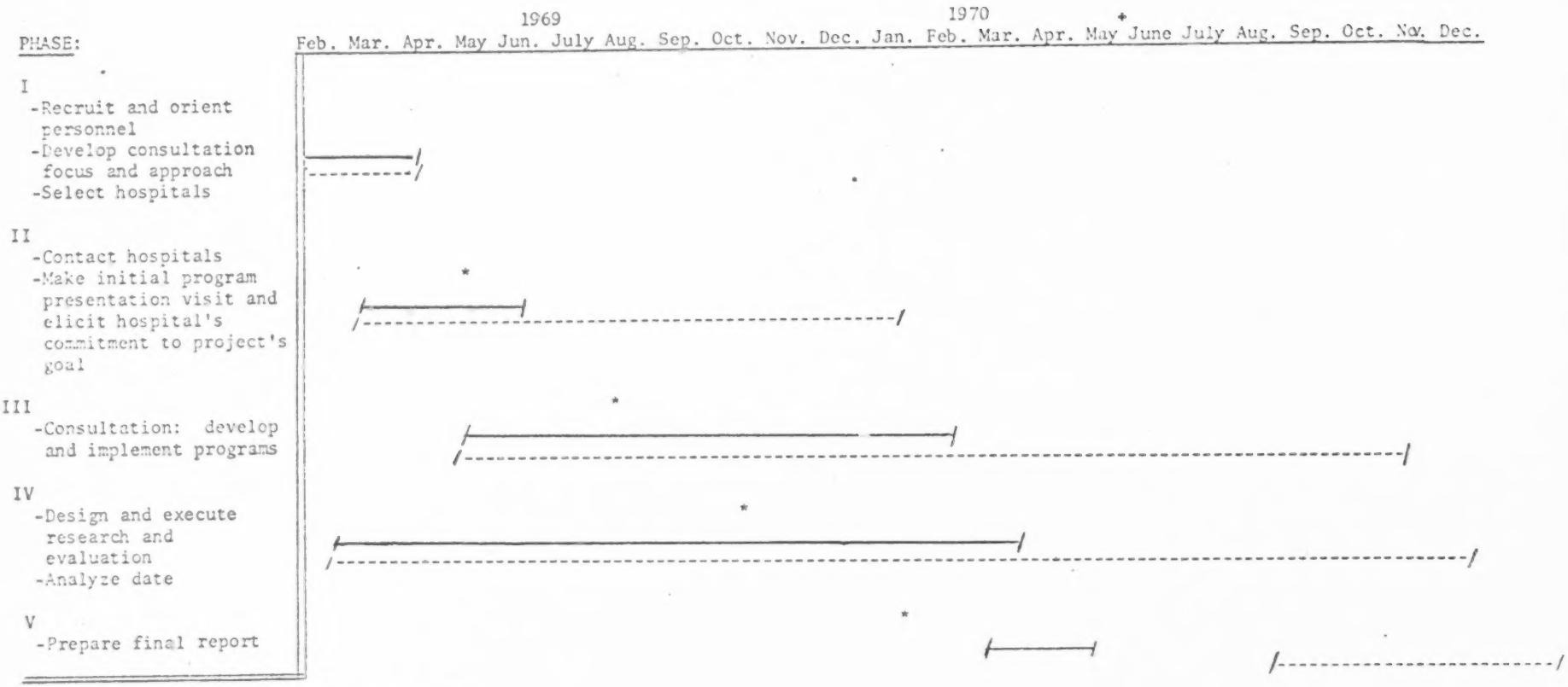
Control of Change Seen as Objective, American Medical News, December 7, 1970.

APPENDIX A

Plan of Progress

Contract No. NIH 70-4149 (PH-108-69-47)

PLAN OF PROGRESS


1969
1970
PHASE:
Feb. Mar. Apr. May Jun. July Aug. Sep. Oct. Nov. Dec. Jan. Feb. Mar. Apr. May June July Aug. Sep. Oct. Nov. Dec.
I
-Recruit and orient personnel
-Develop consultation focus and approach
-Select hospitals
II
-Contact hospitals
-Make initial program presentation visit and elicit hospital's commitment to project's goal
III
-Consultation: develop and implement programs
IV
-Design and execute research and evaluation
-Analyze date
V
-Prepare final report
Implementation Period - designed
Implementation Period - realized
Quarterly Progress Reports
+ Contract extended through December 1970 without additional funds.

APPENDIX B

Proposal to Somerville Hospital

POSTGRADUATE MEDICAL INSTITUTE
UNDER SPONSORSHIP OF THE MASSACHUSETTS MEDICAL SOCIETY

October 14, 1969

PROPOSAL

From Postgraduate Medical Institute

To

Somerville Hospital

To introduce the Postgraduate Medical Institute (PMI): it was established in 1953, and is a non-profit, educational corporation sponsored by the Massachusetts Medical Society. With the continuing education of physicians at community hospitals as its primary concern, the Institute is currently working with over one hundred hospitals in Maine, Massachusetts, New Hampshire and Rhode Island.

PMI's work is, in part, sponsored by a Public Health Service research contract and is designed to help community hospitals develop continuing physician education programs. These programs have generally been of the classic variety, utilizing fairly well known techniques of physician education, and dealing with familiar areas of medical practice in their subject content.

Recently, Postgraduate Medical Institute received an additional contract, to study the development of relevant continuing physician education programs in community hospitals located in depressed areas.

COLLABORATING AGENCIES
BOSTON UNIVERSITY SCHOOL OF MEDICINE — UNION OF EXETER, DIVISION OF BIOLOGICAL AND MEDICAL SCIENCES — DARTMOUTH MEDICAL SCHOOL — HARVARD MEDICAL SCHOOL — HARVARD SCHOOL OF PUBLIC HEALTH — TUFTS UNIVERSITY SCHOOL OF MEDICINE — TUFTS UNIVERSITY SCHOOL OF MEDICINE — MASSACHUSETTS MEDICAL SOCIETY — NEW HAMPSHIRE MEDICAL SOCIETY — RHODE ISLAND MEDICAL SOCIETY — MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH — NEW HAMPSHIRE DIVISION OF PUBLIC HEALTH — RHODE ISLAND DEPARTMENT OF HEALTH — AMERICAN ACADEMY OF GENERAL PRACTICE — COMMONWEALTH FUND

Based upon criteria related to identification of "depressed areas", PMI has selected three community hospitals (Rhode Island Hospital in Providence, Rhode Island; Lowell General Hospital in Lowell, Massachusetts; and Somerville Hospital in Somerville, Massachusetts) in which it hopes to stimulate the hospital and its medical staff to find ways to better meet the health care needs of their communities. PMI's attitude: collaborating successfully with Rhode Island Hospital and Lowell General Hospital, and would like to extend its services to Somerville Hospital.

The Somerville community with its highest population density in Massachusetts (21,000/Sq. Mile) and a relatively low average annual income ($6,021), qualifies as a depressed area and therefore can be expected to have unique medical problems. PMI would like to collaborate with Somerville Hospital in beginning to seek identification and solution to some of those problems.

"Medical problems" of patients from depressed areas are generally considered more complicated than those of people from non-depressed areas. Some problems seem related to socio-economic and environmental conditions prevailing in such areas. Therefore, PMI believes that dimensions of "community medicine" should be included in any education program which seeks to meet the health care needs of a depressed community. In such an approach, the community is viewed as a "patient". Attention is paid to the diagnosis and treatment of the community including its social as well as its medical pathology.

The following are some of the dimensions of community medicine currently receiving major attention by the medical profession.

a) Increased emphasis on the preservation of health or prevention of disease rather than the practice of crisis medicine (or the episodic and sporadic treatment of acute illness). In this respect community medicine blends with the new concept of comprehensive health care.

b) Study of community health problems, e.g., epidemiology of disease. Also, participation with other private and public professional and citizen's groups in studying health problems and in promoting appropriate medical policy and action.

c) Increased awareness of the social pathology underlying a community's health problems(e.g., economic, housing, school, employment factors).

d) Examination of alternative forms of health care delivery systems which might be more responsive to the needs of the community e.g., neighborhood health centers, hospital clinics, group practice, etc.

e) Exploration of the potential for utilizing physician's expertise (e.g., diagnostic skills) in the solution of broader socio-economic medical problems of the community.

f) Stimulation of greater empathy by physicians with the medical and social problems of people from depressed areas.

PMI sees itself as a catalyst helping the hospital define (a) its community's health care problems, (b) its staff's educational needs related to these problems and (c) some possible solutions.

To this end PMI is prepared to employ its consultant staff of physicians, behavioral and social scientists, and educators to work with the hospital in any of the ways outlined below. Any option below selected by the hospital is, of course, open to mutually agreed upon modifications.

OPTION I

In some systematic fashion, the hospital defines those problems recognized to be of particular significance in the Somerville Community. We suggest the establishment of a group composed of leading members of the medical staff's administration and allied health personnel to carry out the assessment. Next, the hospital should establish the corresponding educational needs of the staff. The Postgraduate Medical Institute would then arrange and finance a series of approximately two to five education sessions (Guest Lecture, panel, etc.) geared to the educational needs as defined by the staff of the hospital. Under this option the hospital is free to use whatever methods it deems most appropriate and effective for defining community health problems and related staff educational needs. PMI only requires that the hospital communicate to it the methods used to define community problems and related staff educational needs.

OPTION II

This option includes all elements of Option I plus: Consultation by PMI regarding design of optimally effective formats for the education sessions. Under this option the hospital would

have to provide a planning group to collaborate with PMI's consultants in designing the education sessions. The group might consist of the director of education, members of the education committee, administration and allied health representatives.

OPTION III

PMI's consultation services focus on helping the hospital develop skills regarding the assessment of education needs; i.e., a consulting team which may consist of behavioral and social scientists as well as physicians would work with the hospital to help it learn how best to 1) design and carry out surveys and studies of community problems and 2) assess corresponding educational needs of the staff.

OPTION IV

The Postgraduate Medical Institute could supply two to four educational sessions (lectures, seminars, etc.) for the medical staff of the hospital introducing dimensions of community medicine, e.g., theory of community medicine, epidemiology, new types of health care delivery systems, comprehensive care.

OPTION V

PMI consultants meet with a small group of key hospital representatives to explore the evolving role of the hospital in the community. i.e., to help the hospital define which health and health-related problems can and should be its proper concern. Rather than

providing definition of what can and should be Somerville Hospital's concerns, PMI would help in the analysis of problems, and in the articulation of alternatives. We suggest that such a group include the chief of staff, chiefs of services, administrators, allied health and trustee representatives. PMI could assist the hospital in devising methods of 1) disseminating the insights gained through such deliberations to the staff at large or 2) spreading the discussions to involve the staff at large.

In return for the proposed services, the Postgraduate Medical Institute requires the following of the hospital:

(1) Administrative support (space, facilities and secretarial help associated with convening meetings).

(2) Trustee, medical and administrative staff support for the option selected and its specific requirements.

(3) Administrative and medical staff support and cooperation with PMI's research and evaluation obligations associated with the Public Health Service Contract. Under the terms of its contract with the Public Health Service, PMI is required to research and evaluate the effectiveness of its services and thus must have the hospital's cooperation with the project's evaluation components. In this vein the hospital may be requested to supply data concerning its present and past schedule of educational activities and to make it possible to interview or briefly survey some members of its medical and administrative staff. The purpose of these

evaluative efforts will be to ascertain changes in the nature of the hospital's educational programs which may result from the inputs described in Options I through V.

bb

APPENDIX C

Sample Educational Materials

Edited Collection of Newspaper Clippings
Prepared by PMI for the Rhode Island
Hospital Seminar on Community Health,
July 23, 1969.

HEALTH CARE AND THE PROVIDENCE COMMUNITY:

CRISIS AND GROWTH

Prepared for Rhode Island Hospital by
Postgraduate Medical Institute
July, 1969

Statistics Show Need For Clinics in the Slums

Prov Bulletin 27 Feb, 66

By SELIG GREENBERG

The chances that a baby born in a family in the Elmhurst section of Providence will survive his first year are nearly eight times greater than those of a baby born in a family in South Providence.

And the South Providence infant mortality rate (the rate of deaths before the first birthday) is two and one-half times the overall rate in the sections of Providence outside the so-called inner city where the poor are concentrated.

These are only two of the statistics compiled by the state Department of Health that document the critical health problems in the inner city. Progress for Providence, Inc., the city's antipoverty agency, is trying to solve these problems through its nine neighborhood health centers.

The havoc wrought in the slum areas by poor nutrition and housing, inadequate medical facilities and a [redacted] is demonstrated by a variety of yardsticks used by the state Department of Health to determine health conditions in the 37 census tracts into which Providence is divided.

In 1966, the latest year for which figures are available, Providence had an infant mortality rate of 26.8 per 1,000 live births compared with 22 for Rhode Island as a whole and 23.4 for the nation.

While the inner city had an infant mortality rate of 34 per 1,000 live births, the rate for the rest of Providence was only 20 per 1,000 births.

The inner city comprises 16 of Providence's 37 census tracts and parts of two others. It includes South Providence, Smith Hill, Federal Hill, Olneyville, Fox Point, the Camp Street area, the West End and parts of the Elmwood, Manton and Eagle Park sections.

In 1965 the inner city had a population of 80,928, or about 43 per cent of the population of Providence. It is estimated that 24 per cent of the inner city's inhabitants fall within the definition of poverty with an income of less than $3,000 a year for a family of four. But many other inner city residents are believed to be on the margin of the poverty line. The Elmhurst section, with 149 live births in 1966, had the city's best infant mortality record. There was only one infant death in this section, or a rate of 6.9 deaths per 1,000 live births.

South Providence had the worst record with 24 infant deaths out of 480 births, or a rate of 50 per 1,000.

The three census tracts making up the East Side, with a population nearly equaling that of South Providence, had six infant deaths out of 180 live births, or a rate of 33 per 1,000. This means that a baby born in an East Side family has 50 per cent more of a chance of surviving to his first birthday than an infant in South Providence.

Fertility Rate

In 1966, the Smith Hill section had the city's highest fertility rate (live births per 1,000 women in the 15 to 44 age group), with South Providence a close second. The rates were 126 for Smith Hill, 125.3 for South Providence, 111.2 for the inner city and 76.9 for the rest of Providence.

South Providence had by far the worst 1966 record in the city for the incidence of venereal disease.

The venereal disease rate per 100,000 population was 684 in South Providence, 302 in the inner city as a whole and 113 in the rest of Providence.

State health department statistics for several years prior to 1966 show an equally dismal picture of the concentration of health and social problems in the slum areas of Providence.

In 1963 one of the four census tracts in South Providence had a rate of 266.7 illegitimate births per 1,000 live births, compared with a rate of 61.9 for the city as a whole. The Camp Street area was in second place with a rate of 232.9 illegitimacies per 1,000 births.

The same South Providence census tract had a rate of 206.7 premature births per 1,000 live births in 1963, compared with 82 for the entire city.

Drug Addicts

In the year ending June 20, 1966, this South Providence census tract had a rate of 36.2 known drug addicts per 1,000 males in the 16 through 29 age group, compared with 6.8 for the city as a whole. The Camp Street area was second with a rate of 35.7.

The same South Providence census tract had a rate of 190.7 draft rejectees for physical or mental deficiencies per 1,000 men between the ages of 18 through 24 in the 1966 fiscal year, compared with a rate of 63.89 for the whole city.

One of the three census tracts in Federal Hill had a rate of 2.24 cases of bacterial meningitis per 1,000 population through the age of 29 in the 1963, 1964 and 1965 fiscal years, compared with a rate of only 0.45 cases per 1,000 for the entire city. Fox Point was in second place with a rate of 1.76 cases per 1,000.

In the same three fiscal years, one of the census tracts in South Providence and another in the West End section had an incidence of hepatitis about two and one-half times as high as that for the city as a whole. While the overall Providence hepatitis rate was 0.52 cases per 1,000 population, the rate in these two census tracts was 1.28 cases per 1,000.

One of the three West End census tracts had a rate of 4.4 cases of rheumatic fever per 1,000 persons up to the age of 19 in the 1966 fiscal year, compared with an overall rate in Providence of only 1.03 such cases per 1,000.

National Statistics

Ample additional evidence of the direct correlation between ill health and poverty is provided by national statistics.

These statistics, compiled by the federal government, show that four persons die in the slum areas before reaching the age of 35 for each such death in families above the poverty line.

They show that slum dwellers have three times as much heart disease as more affluent Americans, four times as much high blood pressure and five times as much mental disease.

Ailments that are rare in the higher income brackets, such as tuberculosis, are killers in the slums. Half the children living in poverty never get the standard immunizations against polio, tetanus and whooping cough. Seven of every 10 slum dwellers have never received any dental care.

Nearly one out of every three persons in families with incomes of under $2,000 a year suffers from a chronic condition that limits his activity. For families with incomes above $7,000, the figure is one in 13.

Among families with annual incomes of less than $2,000, men between 45 and 64 average 50 days of disability a year. For the over $7,000 income group, the average annual figure is 14.3 disability days.

Shorter Life Span

Particularly striking is the contrast between the death and disease rates of whites and non-whites.

While a white baby can now expect a life span of 70.2 years, a non-white baby has a life expectancy of 63.4 years. Twice as many non-white as white babies die in infancy. Four times as many non-white mothers die in childbirth. Influenza and pneumonia take more than twice as many lives among non-whites than whites.

These statistics underscore the fact that poor health, family disorganization, delinquency and unemployment are inextricably interwoven; that illness generated or exacerbated by sub-standard living conditions handicaps the poor in taking advantage of even those medical, educational and employment opportunities that are available to them; and that unless concerted remedial action is taken, these limitations inevitably will be compounded for the children of the poor.

The basic objective of the antipoverty medical program is to try to break this vicious circle by providing health care services for the disadvantaged in friendly and familiar surroundings and motivating them to seek such services.

Concluded in tomorrow's Evening Bulletin.

KNOWN PROBLEMS — ARE THERE OTHERS ?

Health Care for All Is a Right, Not a Privilege

Prov (RI) Bulletin
31 Jan 68

I have been requested by the Smith Hill Neighborhood Advisory Committee to responded to remarks made by Dr. Gustavo A. Motta, in an address made by him to the Providence Medical Association.

Dr. Motta decried some of the effects brought about by government financing of medical programs. He cited the opening of medical health centers in Providence by Progress for Providence, Inc., and the new Marathon House in Coventry for narcotic addicts. He said, "Both of these cases were examples of failure to seek medical advice" and "This attitude, it seems to me, was that federal money was available to be spent, and a program had to be instituted. Community health planning was secondary, especially since pre-existing facilities that were available were bypassed."

Several days later, in an editorial, Dr. Motta was taken to task for saying that the motives behind establishment of health centers and Marathon House were "something less than honorable."

The Smith Hill Neighborhood Advisory Committee is not familiar with the services provided at Marathon House, and therefore we cannot comment about them. However, we are familiar with services provided by our health center, and would like to make the following information available.

The program was established because of "needs unmet by general practitioners." Private medical care is not easily available to the poor. They must therefore receive the major portion of their medical care at out-patient clinics, which neither provide personalized nor continuous medical care. The poor, often after waiting for hours on long hard benches to see a physician who often is never the same whom they saw on a previous visit, never return to these clinics, unless it be an absolute emergency. The mother goes to one clinic, her children to another, and when she has another child, she must go to another facility.

A family-centered, easily accessible, neighborhood medical center was set up in the Smith Hill area, next door to a multi-service center able to provide non-medical (social work, casework, vocational, legal) services in conjunction with the medical treatment whenever necessary.

Over 243 families (420 individual patients) have been treated at the Smith Hill Health Center since it opened on May 18, 1967. This is a remarkable figure in view of the fact that the health center is open on a part time basis of about 30 hours a week.

People who need medical attention so badly can now relate to one adult doctor and one pediatrician on an appointment basis over continuous periods of time. The same physicians, nurses, and non-professional aides are all part of a team which insures total follow-up of all patients, and which provides the kind of doctor-patient relationship that the more affluent enjoy, and which all people deserve.

And how have the poor responded — those people who supposedly habitually break appointments, and who cannot be medically educated? Ninety-two per cent keep their appointments, and care about their health. They call when they cannot make it, they drop in to express their thanks, or to report to the nurse how the medication which "their" doctor has prescribed for them reacted.

They become responsible, mature, and concerned parents, they follow advice, and they feel better — not only medically, but spiritually. They have been treated with dignity and warmth. They have been readmitted in the midst of their restricting and frustrating poverty to the human family, and they like it.

Pre-existing facilities were not bypassed, they are just not available to the poor. Medical advice was sought, but the medical community has abdicated its rights and has not met its responsibilities in this great need of the poor and unfortunate seeking medical help.

Health care is not a privilege, it is a right for all, regardless of race or economic level. The medical establishment has not accepted this fact, this moral principle. The sooner physicians accept this fact of the rights of all to have good health care, the sooner the physicians will be able to exert the kind of leadership they should, and the kind of responsibility that they have shirked for so long.

Kay Lovatt,
Staff Assistant
Smith Hill Neighborhood
Advisory Committee
Providence

The 'Right' to Health Care

I wish to respond to a letter in your January 31 Evening Bulletin by Kay Lovatt concerning the so-called right to health care.

Miss Lovatt and the committee she represents are attempting to help a group of individuals in the Smith Hill area who are in need of medical help which, of course, is her right and privilege. She may be doing a commendable job which is to her credit.

I am sure Miss Lovatt deems life, liberty and the pursuit of happiness as a birthright as well as the right to seek employment and retain the fruit of one's own labor. These rights are the inalienable rights to which we all agree and are guaranteed by the Bill of Rights. But, as we all have the right to seek a wife or husband and raise a family, do we have the right to marry a proposed spouse against his or her wishes? Clearly, rights are a two way street; by definition they presuppose that another individual's rights are not sacrificed in the process! One man's rights cannot be interpreted as, or used in opposition to, the rights of another man.

People have just as much right to seek medical care as any other service or commodity.

But, Miss Lovatt stated that health care is a right. Medical care is not a natural resource in a raw unlimited quantity — it is the product of other people's intellect, education and labor. How can Miss Lovatt state within the context of rights and freedom that some people have the right to the fruit of another man's labor? Miss Lovatt goes on to say that this right to another man's labor is a "fact and a moral principle"!

Richard A. Winslow
Cranston

Prov Bulletin,
28 Feb 68

Health care — a right, or privilege?

Prov (RI) Journal - 9 Jan 68

Family Physician Shortage Serious, R.I. Doctor Says

Specialization in medicine has created a situation where more family physicians are desperately needed, Dr. Gustavo A. Motta said last night in his final speech as president of the Providence Medical Association.

Dr. Motta said that the stress of prosperity and new concepts of modern family life, among other basic changes, may cause an increase in mental disorders.

"The pendulum must swing in the opposite direction if society is to be stabilized," he said. "The number of graduating physicians trained for family medicine must be increased, even if it means the diminution in the number of future specialists."

At the same time, he asserted that doctors should make no effort not to leave family medicine for "fixed installations" such as the armed forces and public health programs.

Dr. Motta, in his speech at the association's 121st annual meeting in the Rhode Island Medical Society library, called for federal aid to encourage doctors to take up family medicine.

Previously, he also deplored some of the effects brought about by the present financing of medical programs. He attacked the opening of medical health centers in Providence by Progress for Providence Inc. and the new Marathon House methadone therapy for narcotics addicts.

He said both of these could were "examples of the failure to seek medical advice," he continued.

"This attitude, it seems to me, was that federal money was available to be spent, and a program had to be instituted. Community health planning was secondary, especially since pre-existing facilities that were available were bypassed."

In connection with the advent of "third parties" in the doctor-patient relationship, meaning state and federal governments, Dr. Motta called for doctors to refrain from organizing insurance plans.

Referring to the Rhode Island Medical Society Physicians Plan, he said "Organized medicine should give thought to the feasibility of withdrawing from the insurance business and returning to its own calling — medicine."

He said health plans should be left to groups that specialize in this field.

Dr. Motta contended that doctors have been blamed unfairly for the rise in the cost of medical care.

"I am sure that drugs and hospital costs are the main reason for the increase," he said.

The new president of the medical association is Dr. William J. MacDonald of East Providence, a chief surgeon at Lying-In Hospital and clinical instructor in obstetrics and gynecology at Tufts University Medical School.

Other officers of the association are:

Dr. Nathan Chaset, vice president; Dr. Bertram H. Buxton Jr., secretary; Dr. William A. McDonnell, treasurer; Dr. Alfred L. Potter, library trustee, and Doctors Thomas Forsythe, David Freeman, Thomas F. Mead and Henry C. McDuff, members of the executive committee.

Where should we put our "doctor resources"?

Prov (RI) Journal, 11 Jan 68

Family Doctors

Dr. Gustavo A. Motta, outgoing president of the Providence Medical Association, made some valid points about the shortage of family physicians in his final address to the organization. But unfortunately he overweighted his remarks with opinions that from the standpoint of the public good would better have been left unsaid.

Certainly, most Americans would agree that the shortage of family doctors is of profound concern. Many if not most would grant the possibility that specialization has gone too far, dangerously depleting the ranks of general practitioners. Dr. Motta accurately states the problem, but when he proposes remedies, he reverts to the horse and buggy days.

Commenting on the advent of "third parties" in the doctor-patient relationship, meaning state and federal government, he calls upon physicians to refrain from organizing insurance plans. "Organized medicine," he said, "should give thought to the feasibility of withdrawing from the insurance business and returning to its own calling—medicine."

He asks that federal aid be used to encourage doctors to take up family medicine, but he ignores the possibility of group practice as a means of alleviating the doctor shortage. He urges doctors to resist leaving family practice to go to "fixed installations" such as public health programs and the armed forces, but he overlooks the vital need for doctors in both of those fields.

Perhaps most regrettable of all, Dr. Motta leveled sharp and undeserved criticism at the health centers operating in the city under the antipoverty program and Marathon House, the new rehabilitation center for drug addicts in Coventry. Blithely he dismisses them as examples of "failure to seek medical advice" and charges that the motive behind their establishment was something less than honorable—to institute programs solely because federal funds were available. A fairer critique would have weighed the needs unmet by medical practitioners—the undistinguished record of treating drug addicts and the vital status of health services for people living in poverty.

Dr. Motta might well take a cue from another past president of the Providence Medical Association, the late Dr. J. Merrill Gibson, who five years ago counseled his colleagues: "It must be made eminently clear that we are not always motivated by monetary self-interests, that while we reserve final medical decisions to ourselves, we are prepared to take our place in the life of our community to cooperate in the social and economic problems that beset each and all of us."

PM Sun Journal 21 Jan 1968

Health Plan For Urban Poor Set Up

© N.Y. Times News Service

Washington — A comprehensive federal-private program to provide health and housing facilities for the urban poor — with emphasis on the elderly — was announced at the White House yesterday.

The program will begin in the District of Columbia under the sponsorship of the National Medical Association, with financial and technical assistance from the federal government, the district and Howard University. If successful, it will be undertaken in cities across the nation.

The program links the National Medical Association, a private group whose membership is predominantly Negro, and two federal departments —Health, Education and Welfare and Housing and Urban Development — in what could become a massive drive to bring decent health and housing facilities to the poor of the nation's depressed city centers.

"I believe this project can offer badly needed health and housing care for the elderly and poor in Washington," President Johnson said after a White House meeting yesterday with officials involved in the program.

Mr. Johnson paid tribute to the National Medical Association for taking the lead in sponsoring the program. It is an example, he said, of how "concerned citizens in a voluntary association can work with government" to solve urgent problems.

The association was described by Dr. Lionel F. Swan, its president, as an organization consisting 97 per cent of Negro physicians and 3 per cent of "completely emancipated Caucasian physicians." The whites, he said, are dedicating their services primarily to the cause of humanity.

Dr. Swan announced that the Department of Health, Education and Welfare has made a grant to the National Medical Association to finance [illegible]

The foundation will use the grant to hire a full-time project director experienced in community health, in project design and financing and in working with federal aid programs.

The director will supervise a comprehensive community health survey, first in Washington and later in other cities in which the association has local chapters.

Final plans will be developed from these surveys for the construction and operation of a center offering comprehensive health care facilities. Dr. Swan said the District of Columbia center might be functioning "well within a year."

The proposed complex will occupy a site near Howard University. It is expected to operate in close association with the staff and resources of the Howard Medical School, including Freedmen's Hospital.

The eventual cost, to be raised in large part by financing from the foundation and other private sources, is expected to be about $3,000,000, White House sources said.

Included in the center will be a medical building equipped for group medical practice, a nursing home, social care institutions, housing for the elderly, a medical office building and a neighborhood service center for "senior" citizens. The center will provide care both for the indigent and non-indigent.

Dr. Swan, who is a Negro, stressed that group medical practice alone could answer the health needs of the poor and the elderly in city centers.

U.S. medical schools, he said, are turning out fewer general practitioners and increasing numbers of medical specialists each year. He said that few general practitioners can earn a living in the ghettos and that group practice must fill the need.

PM Journal 24 Jan 68

A Needed Medical Idea

The National Medical Association, a professional society composed mainly of Negro physicians, has undertaken a health project in Washington, D.C. that could become a prototype for cities across the nation. With assistance from the federal government, the District government and Howard University, NMA plans to build and operate a center in northwest Washington, offering comprehensive health care facilities for the poor and housing for the elderly.

President Johnson focused national attention on the plan by announcing it at a White House press conference. "There is nothing I know of," he said, "that we need more urgently in the cities of this country than health care and housing for the elderly —unless it's for the young." He said the program was an example of how "concerned citizens in a voluntary association can work with government" to solve urgent problems.

The center will be built on a 335-acre site. It will include a building for group medical practice, a nursing home, social care institutions, a medical office building, housing for the elderly, and a service center for "senior" citizens.

Studies have shown that slum residents are not generally inclined to seek badly needed medical attention unless an emergency occurs. Children's health often is neglected. As President Johnson pointed out last year in a special message to Congress on children and youth, "In education, in health, in all human development, the early years are the critical years. Ignorance, ill health, personality disorder—these are disabilities often contracted in childhood: afflictions which linger to cripple the man and damage the next generation."

The NMA program in Washington will provide needed health services at a central location designed specifically to serve the poor. By fostering group practice, it will help meet a growing shortage of general practitioners as the profession continues to accelerate the training of specialists. This alone, said Dr. Lionel F. Swan, NMA president, could provide the answer for the health needs of the poor and elderly in the nation's city centers.

The NMA merits praise for pioneering in this field. Its work, it is hoped, will lead to similar efforts in cities throughout America. Medicare and medicaid, health services under the welfare and antipoverty programs have done much to reduce the unmet medical needs of the poor, but much more remains to be done.

In search for a relevant Health care delivery system. —

Is "Group Practice" the answer?

Pawtucket Bulletin 26 Feb 68

Health Clinics: Outposts In the War on Poverty

or what about Neighborhood Health Centers ?

By SELIG GREENBERG

Hundreds of residents of poverty areas in Providence, where people fall ill far more often and see a doctor far less frequently than the average, are receiving medical services in a radically new setting.

Free medical care for the disadvantaged is now available in nine neighborhood health centers operated in the so-called inner city by Progress for Providence, Inc., the city's antipoverty agency.

The first of these centers, in Fox Point, opened its doors about 13 months ago. The latest, in Federal Hill, was established last September. Five of the centers are located in school buildings, two are in former stores, one is in a South Providence community center and another in a housing project.

The centers, which are generally open from 2 to 9 p.m. Mondays through Fridays, are staffed by 18 physicians, most of whom provide services between eight and 12 hours a week. Each center has a full-time registered nurse on duty and two or three specially trained nonprofessional health aides.

The dimensions of the program so far are relatively modest; it still has a long way to go toward closing the gap between the health needs of the poor and the traditional means for meeting these needs. To date, services have been given to about 2,600 persons, only slightly more than 3 per cent of the inner city's population of more than 80,000.

But the major significance of these medical outposts of the antipoverty war lies not so much in what they have been able to accomplish in the initial stage of their existence as in what they may portend for the future.

In many respects, the antipoverty health programs here and elsewhere throughout the country represent important new departures from the established patterns of medical services. The innovations they are introducing are drawing increasing attention from health professionals and may have a considerable impact not only on the arrangements for health services for the poor but on the whole medical care system as well.

Some outstanding features of the antipoverty approach to health care are these:

Medical services are being brought to the places where the patients live instead of waiting for them to take advantage of facilities that often are inadequate and which, for a variety of reasons, they frequently neglect to use.

New kinds of health sub-professionals, drawn from the poor themselves, are being trained and are playing an effective role as a bridge between doctors and patients.

Emphasis is being laid not only on quality of services and preventive measures but on the development of a meaningful doctor-patient relationship with a family orientation and of continuity of care, key elements now often unavailable to the poor.

With careful appointment scheduling, concerted followup and a friendly and dignified atmosphere, the new program is showing signs of reversing the deeply ingrained negative attitude of the poor toward their own health care.

Although hospital outpatient clinics have long been a major source of health care for the low-income groups, many of the poor have shunned them and others have used them only sporadically, often failing to keep followup appointments.

'Poor Get Sicker'

Except in emergencies when it is imperative to seek help, the poor have tended to neglect their health, thereby contributing to the vicious circle in which, as Sargent Shriver, the director of the Office of Economic Opportunity, has said, "the poor get sicker and the sick get poorer."

The reasons for this state of affairs are not too hard to find.

All too often, hospital clinics are overcrowded and have a dismal atmosphere of "charity medicine." Often the treatment is impersonalized and sometimes brusque, patients rarely see the same doctor or nurse twice in a row, and long hours of waiting on hard benches are not uncommon. Frequently it is difficult for the poor to get to these clinics, particularly in the case of mothers who have baby-sitting problems. Nor are the hours in which the clinics generally operate the most convenient for working people.

The neighborhood health centers are deliberately striving to overcome these barriers to health care.

A conscious effort has been made to provide an informal and congenial atmosphere in which people are treated with the respect that patients expect in a doctor's private office. The health aides on duty come from the same neighborhood as the patients and frequently are familiar with their backgrounds.

Cheerful Quarters

Although the quarters are small, they are uniformly cheerful. There are comfortable sofas and chairs, magazines on the table, pictures on the walls and sometimes even rugs on the floor. Except for walk-ins who are treated as soon as a doctor can manage to see them, appointments are made beforehand and there appears to be less waiting than is commonly the case these days in many doctors' offices.

All new patients get a thorough medical check-up that lasts at least an hour. They are sent to hospitals for electrocardiograms and other procedures for which no equipment is available at the neighborhood centers. Where necessary referrals are made to specialists; the nurse or one of the health aides makes the appointments and later checks to make sure that they are kept and the instructions are followed.

The nurse and the health aides in each center perform a variety of vital roles. They canvass their neighborhoods to draw attention to the availability of services, keep detailed patient records, assist the physicians, transport patients to hospitals, make calls at the homes of patients who are confined and even act as baby sitters to enable mothers to keep their medical appointments.

Records at the Smith Hill Neighborhood Health Center, which has been in operation since last May in a former store at 417 Smith St., show that 92 per cent of the patients keep their appointments. Alan L. Skvirsky, acting director of the Providence antipoverty medical program, said this is ample evidence that "if you provide a personal, dignified setting and good medical care, people will respond."

4 Sept. 65

Antipoverty Agency Names Health Chief

By C. FRASER SMITH

Dr. Joseph F. Kerrins of Attleboro was named director of the $400,000 health program at Progress for Providence this morning at an annual salary of $25,000.

Cleo E. Lachapelle, the agency director, made the announcement of Dr. Kerrins' appointment during a news conference in the agency's office at 100 N. Main St.

Dr. Kerrins recently completed 18 months' work in Lima, Peru, where he operated birth control clinics.

In Providence, he said, personalized medical care for those who have not been able to afford it is his broad objective. He said he believes there is a good foundation here for building the kind of program he wants. In some other cities he visited, the bureaucratic tangle made his approach nearly impossible, he said.

The first order of business, he said, will be relocating each of the nine neighborhood clinics in storefronts. Many of them are now in schools. On thoroughfares, the reasoning goes, more people will learn of and use these clinics. The new locations would also remove the need to overcome the anxiety of some adults over going into a school.

"People want to go into a private doctor's office," Dr. Kerrins said. Patients are seen in these clinics by appointment, which they can make by telephone or by dropping into the clinic.

Dr. Kerrins said he believes some very important medical services, including pre-natal care, are not now available in the clinics. In the next three months he said, he will be developing more specific goals for his program here.

He said he is impressed with the enthusiasm of the people who staff the centers and the neighborhood committees which oversee their operations. He said he believes a "monumental job" has been accomplished during the first 18 months of the program by Alan L. Skvirsky, acting director of health.

Mr. Lachapelle also said he and Dr. Kerrins will be traveling to Washington to discuss with Office of Economic Opportunity officials the possibility of obtaining a grant for comprehensive medical services. One of Dr. Kerrins' responsibilities will be to develop such a program for the inner city neighborhoods, he said.

His work, presumably, would attempt to close what the 1969 agency proposal calls a "critical gap between the health needs of the poor and the treatment being provided by traditional, existing services and facilities."

One change mentioned by Dr. Kerrons involves expansion. In the clinic at the Hartford Park Project, 73 patients were seen last week. With that many persons, he added, the clinic is taxed beyond its ability to provide individual care.

During the last fiscal year, which ended Aug. 31, the agency provided services for 3,000 persons. A total of 2,500 families were afforded medical care, more than 1,000 persons were seen more than once.

The agency hopes its program will cut through the "depressing atmosphere of hospital clinics and the necessity for long, complicated, detailed forms and the constant shuttling between various services scattered over a wide geographic area."

A kind of clinic mentality that produces indifference toward medical care results from this "labyrinth of inconvenience, embarrassment and mental anguish," the proposal suggests, adding:

"Apathy on the part of the poor toward their own health becomes a positive factor in disease and should be attacked as such."

It says that in the nine clinics, 80 to 85 per cent of the poor keep their appointments. In two of the centers the percentage is 90.

The state Department of Health, according to the proposal, will incorporate its well-baby conferences into the nine centers. The Head Start Advisory Committee has approved the transfer of its medical program from the schools to the clinics.

Can you get close enough?

Lack of Funds, Doctors Slows Health Program

Prov. Bulletin 2-20-68

While it appears to be successful as far as it goes, the antipoverty health program has had its troubles and is still struggling with quite a few difficulties.

A major problem — one that is common to all antipoverty projects and may get worse in this period of budget pruning for domestic programs — is that of limited funds. Another and equally serious obstacle is an apparent coolness on the part of the organized medical profession, or at least a lack of rapport with it.

The Progress for Providence medical program was given a budget of $254,824 for the 15-month period from Aug. 1, 1966, through last Sept. 1. Of this, $232,910 came from federal antipoverty funds and the remainder was provided by the city in the form of services, primarily the use of space in city schools.

The program is operating under an additional six-month budget of $148,016 in federal funds, plus a local contribution of $13,780. Just how it will be financed between the time the latest allocation runs out and the start of the new fiscal year on July 1 is still very much up in the air.

Average Cost

Exact cost figures for services rendered under the program are hard to come by because it took considerable time to tool up before the start of actual operations. The first open unit, January, 1967, and neighborhood center did not, the rest were phased in over a period of months. Alan L. Skvirsky, acting director of the program, says the best estimate he can provide is an average cost of $100 per patient for the first year of operations.

While there are different versions of the origin of Progress for Providence's troubles with the medical society, they agree on both sides that the Rhode Island Medical Society has taken no formal action either to approve or disapprove of it.

Mr. Skvirsky says unsuccessful efforts were made to obtain approval of the objectives of the program from the state medical society and its help in recruiting physicians. Progress for Providence also has sought the cooperation of the Providence Medical Association.

Negotiations are still under way to have the association appoint a formal liaison committee or to name a representative on the antipoverty program's medical advisory council.

Public Criticism

Privately, some physicians are criticizing Progress for Providence for undertaking a medical program without medical supervision.

Dr. Gustavo A. Motta recently voiced this criticism publicly in his address as the retiring president of the Providence Medical Association. Dr. Motta cited the antipoverty medical program as an example of "failure to seek medical advice." He said the attitude appeared to be that "federal money was available to be spent and a program had to be instituted. Community health planning was secondary, especially since pre-existing facilities that were available were bypassed."

Letters inviting participation in the program were mailed to 67 physicians in January, 1967, by William A. McNamara, then the director of Progress for Providence.

"We want and need your cooperation," Mr. McNamara wrote. "As a doctor you are well aware of the needs and lacks. Help us to help the have-nots, the left-outs, the pariahs of our so-called affluent society."

No Ad Room

According to Mr. Skvirsky, there were six responses. The 18 part-time physicians recruited up to now include six hospital residents. The doctors are paid $20 an hour.

Mr. Skvirsky said that a want ad for physicians submitted by Progress for Providence some time ago to the Rhode Island Medical Journal, the official publication of the state medical society, was rejected. "They said they had no more room," he reported.

When John E. Farrell, the executive secretary of the Rhode Island Medical Society, was asked for comment, he said he could not "recall the exact circumstances" of the incident.

"Any ad submitted to the Medical Journal has to be passed on by the publications committee," he said. "If they were told there was no room, the ad must have come in too late."

WHERE DOES THE R.I. MEDICAL PROFESSION STAND?

Health Centers Have Shown Extent of Need Among Poor

Prov. Bulletin 28 Feb, 68

Why are OPD's Unpopular ?

By SELIG GREENBERG

"I have to admit that until I started working here about a year ago I had no idea of the extent and gravity of unmet medical needs among the poor."

This comment by a woman physician on duty recently at the Hartford Park Neighborhood Health Center was echoed by two other doctors who are among those serving part time in the nine medical centers operated here by Progress for Providence, Inc., the city's antipoverty program.

"I've run into a great variety of neglected conditions," said the woman physician, who declined to permit the use of her name. "I would venture to say that a considerable proportion of these patients, especially in the older age groups, haven't seen a doctor for anywhere from five to 15 years."

Another physician, who described himself as "a concerned pediatrician" and has been serving in the Head Start program as well as in two of the neighborhood health centers, reported that he has "picked up a number of serious conditions, any number of family problems needing case work and many with learning problems."

"Most of these children," said this pediatrician, who also refused to allow the use of his name, "have been through well-baby clinics and have been examined and immunized. But we've found that well over 50 per cent of the youngsters in the Head Start program show growth failure, probably due to lack of continuous pediatric supervision."

Malnutrition may be a factor. These children fall below expected growth and this will interfere with their learning abilities. They should be given special tests and training at an early age."

Both the pediatrician and Dr. David Newhall, a Barrington internist who serves three-hour stints two nights a week at the Smith Hill Neighborhood Health Center, had high praise for the antipoverty medical program. But they also noted some weaknesses in it.

The two physicians lauded in particular the dedication of the nurses and specially trained health aides, the latter drawn from among the poor themselves.

"The nurses are truly a dedicated group," Dr. Newhall commented. "They have a great deal of empathy. And the health aides are the milk of human kindness."

When Mrs. Christine Enoc, the registered nurse at the Hartford Park center who also is in charge of the training of health aides for the antipoverty medical program, was asked why she left hospital work to take this job, she said:

"I prefer it here because in my opinion this is how medicine should be practiced — to try to keep people out their feet. Here you can keep in touch with these people, see what the problems are. You can go up to their homes and find out what's wrong, why they didn't come back if they didn't keep an appointment. From the nursing point of view, in the hospital we have no way of knowing what's happening to patients after they leave. Here we do."

"I had a very negative feeling about this program when I first started," the pediatrician said. "I felt it was a duplication of available medical services.

"But I soon discovered I was wrong. There are few or no doctors in these poverty neighborhoods. Most of them have moved out. The people living in these neighborhoods go to the accident room for crisis care but not for regular care.

"There are many reasons why they don't go to hospital outpatient clinics," he continued. "They may lack transportation or have no one to leave the children with. They're uncomfortable and scared. They usually have to wait long hours and see different doctors and nurses each time they come.

'Family Doctor'

"The quarters of the neighborhood health centers are inadequate. But these centers come closest to anything I know of for projecting for these people the image of a family doctor that many of them have never had. There is a stability to the staff and they are people the patients know and trust. There is no waiting. Everybody comes by appointment.

"The health aides are friends and neighbors. They speak the same language and can interpret things to patients and go to their homes for follow-up if necessary. The antipoverty program also makes available social workers and other services where needed." He added:

"As a germinal idea this medical program is terrific. It's a remarkable device for providing good, dignified service to a group of people who wouldn't get it in any other way."

Citing what he considers weaknesses in the program, the pediatrician listed insufficient compensation to "attract enough good doctors," the lack of 24-hour service the need "to improve supportive services" provided by other facets of the antipoverty program and the lack of a medical director. Dr. Newhall made substantially the same points.

No Satisfaction

Dr. Newhall, who recently completed his residency training at Rhode Island Hospital, remarked that he does not enjoy hospital outpatient clinic practice.

"It's unsatisfying," he said. "You're assigned for a short period of time and very often don't see the same patient again. You don't know who is coming when. It's not like a doctor's office."

But at the neighborhood health center, he said, "people are scheduled. I give them the same amount of time I give my private patients.

"Many of the people in the poverty areas would never go to hospital outpatient clinics," he continued. "They live within a six or eight-block radius and never go outside of it. Even those who go to clinics often fail to follow instructions. Here the health aides know the patients or know somebody who does. They call and nag to make sure that instructions are followed."

Regional Drug Addict Treatment Discussed

- Drug addiction
- Poor housing
- Inferior education

Preliminary discussions on the possibility of establishing regional residential centers for treating drug addicts were held yesterday at a workshop of the Northeast Drug Abuse Council at the Biltmore Hotel.

Walter A. McQueeney, chairman of the state narcotics commission and a workshop participant, said the consensus among those attending was that "a sprinkling of treatment centers" was preferable to a regional hospital.

He said extensive study is needed to answer such questions as how many such centers there should be, where they should be and how many addicts they should accommodate.

The moderator for the workshop, Ernest Shepherd,

CAUSES OR EFFECTS

OF ILLNESS?

Group Goes to City Hall

Dilapidated Houses Object of Concern

By WILLIAM K. GALE

The problems which beset cities such as Providence were set out sharply yesterday in a 45-minute meeting between a citizen's group and a repre-

another group at city hall to complain about the smoke.)

At the conclusion of yesterday's meeting each of the half-dozen houses on Colfax and

Reflections of an American Dilemma

The Providence Journal, May 16, 1969

Student Unrest at Hope Discussed

By C. FRASER SMITH

A panel discussion on education, held during yesterday's Urban Coalition meeting at Brown University, was almost entirely by consideration of the current unrest at Hope High School.

The increasing significance of black awareness must be dealt with in order to pinpoint the causes of the unrest, members of the panel said. Unless the voices of the black students are heard and understood, the causes cannot be brought into focus, they added.

Not all the Urban Coalition members were pleased with the panel's emphasis [illegible] primary function — discussion of problems in urban education.

Anderson Kurtz, a black student at Brown and a member of the panel, responded: The difficulties at Hope High School comprise a microcosm of the nation's most serious [illegible]

"We must solve the problem before we can solve ... They aren't separate problems [illegible]

Earlier, Prof. Raymond W. Houghton, special assistant to the president of Rhode Island College and another member of the panel, addressed himself to the problem of understanding what has happened at Hope.

Dr. Houghton said the entire concept of black awareness is little understood. He said, "I hope the governor will see fit to call a conference on black awareness, close the schools in the state for a day and find out what the hell we're talking about."

Nearly identical sentiments were expressed earlier in the day during an interview with Dr. Arthur L. Biffkins, professor of music at Rhode Island College. Dr. Biffkins has been assisting the black students of Hope—at their request—in preparing their case for the school department.

Professor Biffkins said, "It is not a generation gap. It is a lack of willingness to understand what they're saying.

"Parents all over the city are always saying that the school system must change, but when the kids say it, they get up-tight.

"Although the acts committed by these students may be classified as irrational, as adults we must take time out to find the legitimacy behind them. I do believe these kids are screaming in the dark for guidance and, most of all, a person of integrity to believe in.

"We must take time out to understand and not just listen. We cannot try to give them our thinking, before we understand their thinking," he said.

Dr. Biffkins made these remarks in his sun-filled office at RIC. Behind him on the wall were six small photographs and a poster, the latter showing a black boy eating a sandwich over the caption, "You don't have to be Jewish to love Levy's (real Jewish rye bread)." The photographs included the late President John F. Kennedy, the late Sen. Robert F. Kennedy, the late Rev. Martin Luther King Jr. and the late Malcolm X.

He continued, "I cannot condone violence in any form whether committed by white, black, blue or green. But the important thing is to ask 'Why do our young people feel they can only be heard if violence is associated with their voices?'"

"It is very important that we deal with this, because what happened at Hope is not really an attack on that institution. It is an attack on Providence, the state of Rhode Island—the whole country.

"Whether we like it or not, the climate across the country is developing in a bad way — when you don't like someone, eliminate him without even attempting to discuss your problems.

"If this atmosphere takes over at our institutions of

Continued on Page 2F, Col.

Progress Unit's Director, Staff Quit in Dispute

Action Taken After Meeting With Board On City Hall Control

Is this ~~the~~ our concern?

The director and the supervisory staff of Progress for Providence Inc. resigned early this morning in a dispute over control of the antipoverty agency by city hall.

The mass resignation occurred after a four-hour meeting with the agency's board of directors at the Colony Motor Hotel in Cranston, where the staff presented six demands calling for more independence for the organization.

When the board rejected one of the demands, the 15 staff members, led by Cleo E. Lachapelle, executive director, offered their resignations. The offer was promptly accepted by the board.

This is believed to be the first time in the country that an entire antipoverty agency staff has resigned at once.

The move by the supervisory staff was precipitated by a months-long investigation by a city council committee. Staff members also said the issue of independence from political control, a controversy that started with the agency's formation in 1965, was the major cause of the split.

Frank E. Tabela, board chairman said this morning that he hoped to meet later today with Mr. Lachapelle to arrange for a "cooling off" period.

A meeting to discuss the resignation is scheduled for 9 a.m. at the Urban Education Center. Attending the session will be Pamela Booth, a regional representative of the Office of Economic Opportunity, the federal antipoverty agency.

The demand that divided the board and the staff concerned moving the agency payroll account from city control to the antipoverty office at 400 N. Main St.

Mr. Lachapelle said if the funds were transferred from city hall, "The mayor would lose control of personnel."

"The issue is that P. for P. is a community action agency in the business of running its own programs," Mr. Lachapelle said. "But the real issue is who [illegible]"

[illegible] studied by the board's advisory committee and its financial consultants. He offered to reconcile the dispute with the staff.

"I will ask our staff that there should be some short period for cooling off and negotiations," he said. Mr. Tabela summed up the six demands as a request "for a clear cut resolution whether P. for P. is run by the executive committee or run out of city hall."

The agency, which has an annual budget of some two million dollars, receives virtually no funds from the city. The city does provide services, such as space and equipment, as its share of the antipoverty program.

In the staff list of demands, they charged that the city council investigation "has resulted in a climate of mutual distrust, deep resentment, jockeying for positions and threats to individual staff members and particularly to the agency itself."

The staff urged the board chairman to "appear before the city council to clearly declare the agency's independence."

Mr. Tabela, who was elected to the chairman's job last October, said the "council investigation was a factor" because it reached staff members rather than operating through the board of directors.

The demands of the staff, besides moving the payroll machinery to North Main Street, are:

1. The board chairman inform the city council that the agency "is responsible to its own board of directors and to no other entity."

2. Enforcement of bylaws affecting attendance at directors' meetings.

3. Definition of authority of the executive director, especially the hiring and firing of workers.

4. The board should have the [illegible] agency meetings [illegible] participation in agency

5. The board should take immediate action on a National Institute of Health contract providing for drug rehabilitation.

In the staff statement, it was contended that the executive director has been "subjected to undue pressure" to make appointments and that the same problem arose in the termination of jobs.

"We are prepared to document these accusations," the demands said.

Mr. Tabela said he was reached Friday to arrange the meeting. The session, with 33 of the 38 board members present, started at 7:30 p.m. in a second floor conference room and ended shortly before midnight.

The board chairman said the staff "wanted complete action and sanction by the board."

"But the board was rather surprised at the list because they were not prepared at all to discuss it," Mr. Tabela explained. "The board felt they did the best they could."

Staff members who resigned, besides Mr. Lachapelle, include:

Alan L. Skvirsky, director of education; the Rev. Benjamin G. Mitchell, deputy director; Myron Nalbandian, director of planning, research and evaluation; Isadore Ramos, acting director of ground work; Francis DePetrilli, assistant director of casework.

Paul A. Buckley, casework director, John R. Long, Concentrated Employment Program director; Joseph F. Kerrins, health director, Jeanne Burke Patterson, neighborhood organization director.

J. Webb Mangum, CEP deputy director; Sherwin Zaldman, director of administration and personnel; Joseph Connell, administrative assistant; Vito Russo, director of counseling; Susanne T. Shaw, social planner, and Charles N. Fortas, chief, neighborhood organization.

The Evening Bulletin

PROVIDENCE, MONDAY, MAY 5, 1969

Heal the Wounds

Now that a modified *detente* has been reached between the board of directors of the city's anti-poverty agency and a group of dissident supervisory staff members, an earnest effort must be made by all concerned to heal the wounds, make up as much lost time as possible, and carry the program forward.

The struggle waged over the last two weeks brought the agency, Progress for Providence, to the brink of dissolution. It broadened the split between two factions on the board and doubtless engendered deep resentment if not open hostility between some members of the staff and board members who failed to support them.

Most important, perhaps, the board's decision Wednesday night to invite protesting staff members to withdraw their resignations and return to work shifted the balance of power in the agency slightly away from the political establishment. That the resolution passed by a single vote among 39 directors voting shows clearly that the bloc dominated by elected public officials has by no means been eclipsed. Clearly, its loss is a matter of prestige, not voting power or ability to influence future actions of the board.

The staff's decision to go back was the right one. It might have held out for a guarantee that the sole remaining issue be resolved to its satisfaction, that is, that the agency's payroll operations be transferred from City Hall to anti-poverty headquarters. It would have been a foolish, if not disastrous step, since the transfer appears almost certain without prolonging the *impasse* and risking complete disintegration of the program.

While the crisis has been cooled, the fires of discontent continue to flicker in several quarters. Extinguishing them will not be easy and will require a generous amount of wisdom and restraint. Board resentment over the walkout must not influence the impending re-evaluation of individual staff members. If morale of the entire organization is important to the officers and directors, as it ought to be, fair standards must be observed fastidiously.

Surely the first order of business must be to implement the recommendations of the Office of Economic Opportunity and the fiscal changes urged by the accounting firm of Peat, Marwick and Livingston Co. in a study just completed.

By a thin hair, Progress for Providence has survived a serious crisis. Improper political peddling has received a justified setback, but that does not mean that staff ultimatums can or ought to be condoned in the future. As OEO has wisely pointed out, channels of communication within the agency must be used more effectively. Teamwork in spirit and reality is essential to an effort of this kind. Without it the whole effort is a farce—a waste of taxpayers' money, a struggle for self-aggrandizement, political or otherwise, and a cruel hoax perpetrated upon the intended beneficiaries.

We hope that the anguish of the last two weeks has taught us these lessons.

Crisis cooled —
but real work
remains to be done

APPENDIX D

Sample Education Program

Rhode Island Hospital
Seminar on Community Health

July 23, 1969; 4 - 9 pm

Edited Proceedings

Educational Session

Rhode Island Hospital

Colony Motor Hotel
July 23, 1969, 4 p.m. - 9 p.m.

Proceeding of the Seminar - Not a Verbatum Account

CONFIDENTIAL - NOT TO BE REPRODUCED

Afternoon Session

Opening:

President, Board of Trustees:

The purpose of his seminar is to discuss some of the problems the Hospital is faced with. They are part of the urban problems which, I believe, revolve around housing, employment, health. I do not think this seminar should address itself to all these problems, but I think we are qualified to talk about health. First we should talk about the existing unresolved problem, and then come to some guidelines on what can be done to alleviate it.

Rhode Island Hospital Liaison Physician to PMI(Chairman of seminar):

This is a closed meeting, "of, by and for RIH" which is to discuss the Hospital and its relation to the outside community. Providing care has been a long tradition of Rhode Island Hospital, some people outside think of it as a city hospital. Nevertheless, we have lately gotten our share of the 'Yankee go home' notion, and

have been picketed. We are concerned to find out where we are in this community, let us discuss what the goals of the Hospital are.

PMI introduced

Contents of folder mentioned

Questionnaire administered

Executive Director, Rhode Island Hospital:

I will give a historical perspective of what has been going on the last several months for those who have seen only one or a few aspects of it. The background to the current problem are "hundred years of doing our thing."

1) Rhode Island Hospital has always cared for the sick poor operating on the basis of "availability to those who came to the door."

2) Rhode Island Hospital stayed in South Providence when it could have gone elsewhere.

3) Rhode Island Hospital was primarily concerned with the people in the state. We did not give special consideration to services in South Providence. I admit, we did not recognize this too much as part of our development.

This outlook is being challenged today. The problem is the OPD. Our outpatient services to all who come there are of high quality. Because we were concerned about the physical environment, we are planning a new ambulatory building. In an attempt to improve the "typical outpatient department situation" (no appointment system, no continuity), in December 68, an

ambulatory services committee consisting of medical staff members was formed that was asked to make suggestions on how to deal with the situation, to improve it.

In January, 1969 the first confrontation with a militant black community group led by "Buddy George" occurred. The group walked up to the front desk and demanded an audience with the Hospital top leadership. It was granted, but at a later date.

The Hospital formed a committee that met with Mr. George as head of the "fact finding committee." Mr. George asked for funds, particularly for two Neighborhood Health Centers (NHC) in the community. He asked: "What have you really done for us?" and said that the Hospital is destroying their homes, that there is no dialogue between the Hospital and the surrounding community, and that people from the Hospital just drive in and out of it, but don't know what is going on there. NHC;s are the one good thing, he said that Progress for Providence has done. They provide dignified and personalized care (appointment system, continuity, etc.) He contrasted this with the way people are cared for in the OPD (no warm situation, no continuity.)

As to Mr. Georges demands to fund two NHC's, the Hospital answered that it was in the health business, not in the fundraising business. From then on, however, we (the committee) concerned ourselves with getting knowledge about the NHC's.

There was a second meeting of the two parties at which Mr. George again presented his demands. The hospitals reply was that it was concerned and would want to help, but, again, was not

in the fund raising business. At the end of the meeting, Mr. George presented a list of "non-negotiable" demands:

1) One Black should be on Board of Trustees
2) Board of Trustees should meet with black community
3) List of hospital payscale and personnel policies should be made available
4) $2000 per month per NHC(two) should be provided by Hosnital
5) 4-6 hours per week of physician staffing should be provided
6) more training and recruiting of black RN's and LPN's
7) barbed wire should be taken from parking lot fence

Then there was a conference on Health Care in the Urban Ghetto arranged by Brown University and the Health Department. The conference took place at the Rhode Island Hospital and during about two hours was picketed by elements of SDS from Brown and later by people from the neighborhood. Their signs said for instance "What has Rhode Island Hospital done for South Providence?", "Love thy neighbor, support the NHC's."

March 22, 1969. The Board of Trustees of Rhode Island Hospital approved a new policy, it said that it would support activities of the Hospital beyond its boundaries, i.e., health care for the poor in the surrounding community and involvement in the NHC's.

Presently there was a meeting proposed for all involved parties (Dr. Kerrings, Progress for Providence, Mr. George, Rhode Island Hospital, Health Department). Dr. Kerrins said, the NHC's are in need for funds, they must be funded by various agencies

and the Hospital is one of them (Progress for Providence had stopped funding them at that time). The Hospital felt, however, it should not be a funding source and had expected help in this respect from Dr. Kerrings and the Health Department. I would say that the meeting was not all that successful. Mr. George did not feel we were responsive to the needs of the NHC's.

On April 10, 1969 there was a meeting with the NHC's. Mr. George wanted a token of the hospital's support. The President of the Board of Trustees agreed to supply some kind of tangible property (refrigerator for one center and other supplies.)

Mr. George took some hospital administrators and trustees on a tour through South Providence.

The most recent meeting was cordial, Mr. George is interested in being wrecking contractor for the hospital, moreover, he is beginning to see tangible evidence of the Hospital's concern and activities. This is how far we have gotten, we would like to meet with other leaders of the community.

Director of Personnel and Public Relations:

The Hospital started to examine its relationship to the community in 1964 on request of the governor. It was urged to change employment policy to hire more blacks. In spite of this, however, the percentage of blacks hired stayed more or less, the same around 8%. This is because qualifications and skills still remained the most important criterion in selecting personnel. To change the situation in the desired direction, this policy must

be changed in the direction of hiring people with potentials and then organizing supplementary training programs for them. The hiring standards must be changed. Along with this, sensitivity training for supervisors is crucial. We had such a program very recently for department heads. In the future, we hope to have sensitivity training sessions for supervisors who immediately have to deal with employees from the surrounding community. One thing is clear, we need more people, there are 340 openings. Altruism aside, our very interests demand this new policy.

Rhode Island Hospital is participating in the Laboratory Education Advancement Program of Brown University and several young men (14-15 years old) from the community are placed in laboratories of the Rhode Island Hospital.

A questionnaire was sent out recently to 3900 employees to find out who wants to be kept informed of new activity with regard to the community and who wants to become involved. Many wanted to become involved, but as for participation in actual opportunities that we listed, few really did get involved.

A program called Keep in Touch (KIT) is meant to provide contacts between the community and concerned agencies. The Hospital was represented at meetings, but few community residents attend the meetings.

I was told that a group of children from South Providence need screening for summer camp. I asked Dr. Feinberg, and he had done the screening for several years now.

The Hospital is called racist by the community. It was

a shock to me, when I first heard it. It is because we don't really know what it means. Rhode Island Hospital is one of the largest employers in the state; but the black community is underrepresented. They are right, we are a racist institution.

Director of Psychology:

Sensitivity training sessions were held in June and July. Twenty-four out of fifty department heads took part. There was a film series and discussion including 2 confrontation meetings with militant blacks. We wanted to investigate how a well meaning institution such as Rhode Island Hospital could be conceived as racist. Some of the participants are starting to change their perception, are becoming more accepting, and beginning to see things in different light. Hopefully more programs will be initiated.

Question: Should we react to the community or be proactive ourselves?

President, Medical Staff Association:

The hospital is faced with changing its medical care delivery system. Mr. George's complaints were right, but not because we are racist. We short changed all the poor, black and white. The medical staff will get a letter, we decided to ask them to get involved as individuals in the delivery of care to these people. These are to be top level discussions to start twisting the staff's arms. The Hospital must bring its diverse efforts under a coordinating umbrella.

Chief of Medicine:

For five years we have been talking about the same problem. We are caught in a social force. Don't look for credit, what we will do is going to be taken for granted. First get out and do more, and expect little but more pressure.

Director of Personnel and Public Relations:

Yes, as we do more we will get clobbered more. This is the reason why we probably won't like it. But we must.

President, Medical Staff Association:

We must learn to take the clobbering. We don't solve problems, but only create new ones. And you don't have to be an idealist to do something. It is a matter of self-preservation, you can do it from a purely selfish point of view because it means the survival of our society.

Director of Nursing (R.N.):

Before and after Mr. George's demands our association contracted Progress for Providence for candidates for Nursing School. A few were found. Things were not easy, the hospital tried to make up deficiencies in credentials and financial support. The young women have been a source of education to the hospital. We learned that they do not keep up with school because of fear and anger. They have different ideas on money management than poor whites. Budgeting is a foreign concept. They are different from

other students and we have learned a great deal from them. The program is bigger this year (10 out of 91 enrolled). We need help to understand them as people with unique problems. We are also starting a nursing assistants program, no high school graduation is required, only good reading skills and legible writing. After a 12 weeks course they are nursing assistants.

President, Medical Staff Association:

The new ambulatory care center even if it existed today would not fulfill the needs as the South Providence Community sees it, and they would not use it. I think what they want is something close to a family doctor. And incidentally, they want control. They want to determine the time when they can come, and not come at the convenience of the physician. It is a different thinking that is involved here. I hope you realize that.

Chairman, Ambulatory Clinics Committee:

I agree, but I think the hospital will eventually lure people back. Until then, however, the problems may have to be solved their way.

Question: Are things so bad? We have a Welfare Department.

Chief of Medicine:

If you would make the rounds some of the trustees have taken in South Providence you would know. Would the Vice President of the Board of Trustees give us his impression of what he saw there?

Vice President, Board of Trustees:

The problems are terrible.

Question: Are the problems one of failure to get services, help, or is it a matter of services not being available?

Chief of Medicine:

It is a failure to get things. They don't know how to make demands. Buddy George said to me: "You would not allow garbage not to be collected, you would know how to have houses cleaned up!"

Question: Why are we talking about garbage, is this a reponsibility of Rhode Island Hospital?

President of Medical Staff Association:

They don't know how to get medical services either and want to get the Hospital to help them and be a good neighbor and become involved in their problems and solve it the way they want it to be solved.

Another Speaker:

We are not the salvation army, this is a matter of Welfare and concerns not only the Blacks.

Chief of Medicine:

One cannot view things too narrowly. I think the Board of Trustees has taken a broad, enlightened attitude. It was

wonderful to see its president take our the Kerner Commission report and say: "Gentlemen, you have got to read this to know what is going on in our country!" And this is what they want us to do, become involved in their problems and help them to get out of that terrible mud they are in.

Another Speaker:

I think what was mentioned before is really true, that they want a family doctor they can have a relation with rather than walk into this large impersonal white institution where they see no black faces except for their fellow patients. They feel alien and on foreign territory. Take the appointment situation. I know what is going on. Our overworked pediatrician gets an emergency call in his practice and gets to the OPD only at 11. His patients have been waiting since 9. They don't know what has happened, they don't see this other side.

Director of Ambulatory Services (R.N.):

Free service is just impossible today. There is a crisis going on in how hospitals become reimbursed for services. Particularly for the last five years, most of our services deal with socioeconomic, emotional, behavioral problems. There just is not enough medical staff around to take care of these problems. People coming to OPD appreciate the treatment by residents, there is continuity. But such care costs much money today, residents are being paid, even interns. How are we going to solve the situation?

Liaison Physician:

Is the OPD in competition with the NHC's?

Director of Ambulatory Services:

No, because NHC's have very limited staff, they can't cope with the demands. We get many referrals from NHC's. Many patients do not want to be referred back to NHC's.

Liaison Physician:

Dr. X(NHC physician), you are working in a NHC. Could you tell us why people like NHC's?

Neighborhood Health Center Physician:

The NHC doctor serves a purpose, he has a relationship to the community. The patient-doctor relationship as existing in NHC's should be continued. NHC's are there to stay. They should be supported by the Hospital. Rhode Island Hospital could supply administrative expertise to NHC's. The centers have taken on a social focus, and, identity has been established with the doctors. But most are house officers and can't give long-term continuity. The staff physicians should give leadership. The red tape in hospital (for clinic referral) should be cut.

President, Medical Staff Association:

A man like Dr. Chazan, don't forget, volunteered because he thought something has to be done. That is the kind of person that creates a good doctor-patient relationship. In OPD's, however,

doctors are assigned to the service, it is something to be gotten out of the way. This creates a different doctor-patient relationship. They like doctors at the NHC's at present because it is selective. Once physicians get assigned to NHC's the relationship may deteriorate.

NHC Physician:

I am sure, enough people from the staff would be found to volunteer, so that nobody would have to be assigned.. We must find incentives for senior doctors to go to NHC's. We must do something now, we can't wait till the ambulatory care center or something else is completed. OPD's can't be done away with, it is not an "either or" problem. Thus, for instance, the emergency room is overburdened because people can't sit in OPD and miss a day's work. There should be a facility available after 5 o'clock. We should also educate and motivate community people to work in the health care delivery system of the hospital. Self-esteem must be instilled.

Executive Director, Rhode Island Hospital:

As for help in their administration, it is possible, but it costs money (for NHC's to use modern techniques). There is not a mechanism for dialogue between Rhode Island Hospital and the Centers. Progress for Providence is not working well. The Directors quit, doctors quit, it is difficult to work with them. Model Cities is going to fund South Providence NHC's but it does

not have the same philosophy as Progress for Providence.

Chief of Medicine:

But the thing is if you talk to doctors, they all like NHC's, possibly someone in the administration might like it, too. (laughter).

D.D.S., Director, hospital dental clinic:

"It hurts to hear that these folks don't feel at home because doctors are whites." That is not true. We never had any complaints. God help them if they did not have us in the 30's, and God help them now if we did not continue the OPD. The problem has been exaggerated here. The NHC's are great for socio-economic cure. But to take care of the health of the nation you have to have the manpower, the womanpower. I have never seen any Rhode Island Hospital personnel show any signs of racism. (for 37 years) I just don't think it's true. There has never anybody been refused from Rhode Island Hospital with or without money.

Chief of Medicine:

How many chief of service on this staff are black, Sir?

D.D.S., Director of hospital dental clinic:

That's not the point.

Chief of Medicine:

That's precisely what they say it is (rasicm)

D.D.S., Director of hospital dental clinic:

Who?

Chief of Medicine:

Mr. George, the others.

D.D.S.,Director of hospital dental clinic:

Not the people I know, middle aged and old people.

Chief of Medicine:

That's the problem, sir!

Question: Dr. X(Chief of Medicine), are you saying that the standards we have set up for health care in this Hospital are too high?

Chief of Medicine:

No, sir, I am only saying how they view it. There are not enough Negro physicians, not enough Negro students in medical school or nursing schools, because they are not qualified, qualified by your standards, namely, based upon white middle class upbringing and not qualified by you who kept us down by selling us your standards and then telling us we are not good enough to meet them.

Question: Is the solution to this then to lower standards?

If we lower our standards, then the service is going to get poorer and, in the end, those people who now demand lowering the standards, are going to suffer.

Chief of Medicine:

There are two answers to that: 1) help us come up to your standards, and the second point is 2) we are not so impressed by your standards. Even with service of lower standard we will be better off than we are now, because we are getting zero. What is it of use to us if standards are high if we get nothing. South Providence has only 3 physicians.

Another Speaker:

They want 100 black students in Brown University Medical School, in First year class.

Chief of Medicine:

They say: don't tell us we are not qualified, get us through (even it it takes us 5 or 6 years). I know you will say, black physicians are not more likely to practice in ghettoes than the whites who don't go to rural areas. But their answer is: help us upgrade those Black students so they can get through school.

We can always talk about quality of medical students. I am not saying that I agree with their demands, I am just saying how they see it. This is their judgement. You can ignore them, if you want to, but it will be at your peril!

President of Medical Staff Association:

We have to recognize that the white community is responsible for the position the black community finds itself in. If we accept this we must take the next step, even at the cost of what you outlined. Make the medical system, the educational system more responsible to the demands of the Blacks. But I must say, the first thing is to recognize the problem, then to take the next steps. I know what prejudice is, I remember the first Negro intern in Rhode Island Hospital and the discussion going on among staff of whether one can let him do a pelvic on a white patient. Is that not prejudice? We have to recognize that.

Dinner Break - slides were shown of the tour with Mr. George through the South Providence Community.

Evening Session

PMI Physician Consultant:

(Who was asked to give his reaction to what had been said in the afternoon session)

1) The hospital should help the community to build up an organization that represents the community. It would be easier to deal with such a representative body. Help the community to develop to the point where it can negotiate with the hospital man to man. 2) We have to find a new approach to health care that would include the invisible sick. Whose responsibility are they? The health Departments? A new liaison between Health Department - Hospital - Private doctors is necessary for dealing with this problem. 3) As to standards, is the treatment of the acute sick enough? I don't think this is a good standard. One must see the total patient. Take the problem of a tired young woman. It's not a medical problem but why is there no day care center for her children. Can we advocate such a center? 4) As for funding: determination, if it exists, takes one a long way. Be prepared for a long battle and energy and expense. You should build an organization, a mechanism for embarking on this battle.

Another Neighborhood Health Center Physician:

There are unique features to NHC's: 1) They can teach and motivate people how to use medical facilities. 2) They can be good for career development programs. These two features are part

of the concept of NHC's. Moreover, psychological and social problems can be well treated. A social worker from Rhode Island Hospital could resolve many problems in the NHC's. Now, Progress for Providence is not doing a good job in running these centers, it is hard to judge, therefore, whether the shortcomings of the centers in South Providence are inherent in the concept or not. Love of neighbor is not enough, training could be done by the hospital. NHC's in Providence have gone from crisis to crisis, they had no opportunity to function. If helped along by the hospital, they would maybe improve. It is also very important to develop the ego of the people in the community. There was an incident where they choose a chiropodist instead of an internist. Now, this may be the wrong decision, but it is their decision, and that is what is important.

Question: How have NHC's developed?

President, Medical Staff Association:

It is an old concept, city hospitals developed them because transportation was a problem in those days.

Another Speaker:

The name developed out of the Office of Economic Opportunity Program Act.

PMI Physician Consultant:

In all seriousness, they evolved when the first physician set up his office in the neighborhood in which he lived.

PMI Anthropologist Consultant:

And there are no such offices in the inner city. Could the hospital make a financial commitment?

Executive Director, Rhode Island Hospital:

We are a long way from financial responsibility for even one. But finances are not the issue, it is an organizational problem. The OPD/s cost a 1.2 million. While Model Cities will fund the 2 centers, the hospital will have to provide back-up for red tape cutting, etc. The emergency room visits have not risen over the last two years, this is partly due to the NHC's. The folution of the problem could involve group practices and the private sector in addition to the hospital administratrion.

PMI Executive Director:

If there is an organizational problem, who in the hospital is supposed to deal with it recognizing that the problem can't be solved without Rhode Island Hospital? Can there be created a mechanism dealing with the South Providence problem and another one dealing with problems of the state?

President, Medical Staff Association:

We can't set up the mechanism yet. We should move where we can. One thing at a time should be done, trial and error method must be applied. It's an evolving process.

PMI Executive Director

The system of trial and error is not being approved any more. An organizational framework is needed for a basic organized, systematic approach towards dealing with the problem that came up today.

President of Medical Staff Association:

One more element: the organizational set-up must include community people. If they want doctors, I think we should get set about getting them doctors. Doctors going into the centers can teach the people to avail themselves of medical care as was pointed out.

Executive Director, Rhode Island Hospital:

The state does not support the kind of community centered approaches we have been discussing today.

PMI Executive Director:

I do not mean to say anyone can solve the problem, we began with that premise. What was said today, though, was that we should have a set-up to continuously deal with the problem.

The problem is going to be continuously with us. So why not have a set-up that would continuously deal with it? Including a communications network so that we can work with ever changing problems for a long time.

PMI Psychologist Consultant:

As we need a hospital organization, we need a feel or "sensor" of what is going on in the community. The client-doctor relationship is changing. The client, now, has a right to talk to his doctors. To want to collaborate is not enough. Skills on how to collaborate are necessary.

Liaison Physician:

Would NHC's solve all problems?

Director of Personnel and Public Relations:

This is a difficult question. I believe that we would be happier in our relationship with the community if we were to help the NHC's. I agree with the Chief of Medicine concerning the serious nature of the problem, of the emergence of two societies, one black, one white in our country, and of the bitter confrontations that are impending. And I can't see how any institution, non-profit or profit, can possibly divorce itself from coming to grips with this problem. This situation is so bad, and getting worse constantly that it is a matter of survival of our institution and the profession. There is no limit to what we should do, because the survival of the society is at stake.

Chief of Pathology:

How many (blacks) are we talking about. 5% of Providence population? 1000, 1200?

Director of Personnel and Public Relations:

8% of Providence are black and 50% of South Providence- Argument ensued concerning the accuracy of the figures.

PMI Executive Director:

It is indicative of the extent of the problem that we do not know whom we are talking about.

Chief of Medicine:

Figures are not the issue. They constantly change, the more we do the more we are expected to do. The issue is: is this organization willing to address itself to the problem, and if it does, does it do so to the very best it can. Nothing is going to be resolved by numbers. We must address the problem as a moral challenge.

PMI Psychologist Consultant:

I think, it's somewhat disastrous that a group as concerned as this one can't go beyond the problem of 2 clinics, and can't see that it should systematically diagnose and relate to the community. This is really the core issue: how do we become aware and stay aware of a continually changing pattern so that we can adjust to it.

President, Medical Staff Association:

Well, I think you are going too fast, because you must recognize that our hospital is a community hospital. We are keeping up with the new concept of community medicine, and are going outside the walls of the Hospital, and our immediate concern are the 2 centers next to us. And actually, they forced it down our throats. They awakened us, and I am sure we are going to move into these problems.

Chief of Medicine:

Did they open your eyes only to the two clinics?

PMI Psychologist Consultant

The medical staff should be oriented to the larger level of the problem. The two clinics are test cases for a more general competency to solve community health problems. The concept of community hospital is being redefined from the outside.

Chief of Pathology:

This is too much for us to do, we haven't the resources.

PMI Psychologist Consultant:

No, this hospital is so wealthy!

PMI Anthropologist Consultant:

It has a staff of 400 doctors and is the 3rd largest employer in the state. And you say that you have got resources.

Chief of Pathology:

It is impossible. Our problem is an emergency situation. It is our task to put out the fire. If we go beyond, we have to know what are the problems. Then, how can we solve them. Whether by personal commitment or other is yet another question.

Chief of Pediatrics:

The Rhode Island Hospital has the opportunity to be a pilot. We could demonstrate to other areas of the community and to other hospitals an approach away from the concept of putting out fires. They cannot take care of their own neighborhood, but need help, all community hospitals must help.

Chief of Pathology:

Why hospitals at all, we have indeed government on all sides.

Chief of Pediatrics:

You know, of course, what is happening with the government, they are not doing much.

Chief of Pathology:

What about the rest of the community (whites), the Blacks are threatening, making a lot of noise.

Chief of Medicine:

Do you want a direct government medical care system? That's what will happen! The government will step in if nothing happens!

Chief of Pathology:

We don't have enough resources to solve the problem.

PMI Executive Director:

Why does not the hospital then use its know-how and bring in government and other resources and mobilize people to deal with the problem in a better fashion? This is not an unreasonable suggestion.

Director of Psychology:

That brings us back to what Dr. X, PMI Psychologist Consultant was talking about, we have the know-how the expertise and skills. We have about the lowest concentration of Negroes in New England. If we can't deal with the problem, who can?

Dr. X, Member Ambulatory Services Committee:

You have to strike a balance between idealistic hospital do-goodism and practicality on the other hand. This

seems to me a case where A says: B needs this. Now, C what are you going to do about it? One has to be very sure before one sets about to help, what it is in the area that A, B, and C wants. We have to be sure to have a representative body telling us what the wants are.

Chief of Medicine:

Can't we build on the assumption that the community around wants NHC's.

Member, Ambulatory Services Committee:

I am not sure whether Buddy George is representative of the community.

Chief of Medicine:

How do you find out? How do you account for the fact that 92% keep their appointments there?

Member, Ambulatory Services Committee:

Still, we don't know what the needs are.

Chief of Medicine:

How do you find out, go to the individual houses and ask? Are we not to accept the demands because we do not trust Buddy George to represent the community? He was disignated as their representative, he was chairman of the "fact-finding" committee!"

Member, Ambulatory Services Committee:

So he came around, and what did he say?

Executive Director:

He said he wanted money to support the NHC's and made several other demands.

Member, Ambulatory Services Committee:

Yes, that's right, we should first find out what South Providence people want, otherwise we build a house of cards, or put the cart before the horse. The problems we are talking about are broad social problems, are family problems (not medical.)

Chief of Medicine:

So we do not address ourselves to medical problems because it's a much bigger problem, and we must await somebody to take care of the bigger social problems?

Member, Ambulatory Services Committee:

The Hospital cannot provide care for everybody.

Chief of Medicine:

But can we improve the medical care situation?

President, House Officers Association:

Unfortunately, at present, residents are not wanted in NHC's because they do not stay long. I work in the OPD, and

have heard from people how they trust "their" NHC physician, how they appreciate a doctor they can relate to (continuity). I know that they rather wait for months for a doctor they have been patients of to do surgery on them than have someone from the Hospital do it whom they do not know. This is a paradoxical situation, because surgeons in the Hospital do not get enough patients. Rhode Island Hospital should become involved with the NHC's; with its manpower it could meet the demands. There is a group of residents who really want to become involved, they even want to volunteer for Progress for Providence. Alone for selfish reasons the hospital should support NHC's, it would be very favorable for the education of senior residents. As I pointed out, we would find good teaching materials in the NHC's. A good co-relationship between teaching, education, on the one hand, and health care in NHC's on the other, could evolve.

President, Medical Staff Association: Commenting on results of the Seminar:

This meeting has been a wonderful thing, we don't get to know each other every day in the Hospital the way we did here. So many of us know so much, and are so interested in the problem. I am moved by this experience.

Executive Director of the Hospital:

The discussion has given us a concept of hospital-community involvement, and of the magnitude of the problem, we have an organizational structure working on this, its effectiveness

will be judged later. The problem is tremendous, it needs a lot of expertise, experts have to deal with it.

PMI Executive Director:

PMI is meant to be a catalyst. An educational process has gone on today, because to stimulate and promote interest in the problem is an educational process in itself. But education in any of its forms must have a goal. A reason for teaching is transfer of information, attitude change, action change.

As Dr. Golodetz (PMI Physician Consultant) pointed out, this hospital is not behind the times. The problem is tremendous, but it's not bigger than the whole problem of continuing physician education. It is hard to get physicians to accept the concept. Uncle Sam is concerned and might do something about it. But hopefully, we can do something about this ourselves. My hope is that out of this session will come a continuous commitment to dealing with the problem and that a physician education program will develop that will spread awareness and commitment to the staff at large.

Liaison Physician:

Yes, we have to explore this further, we muct carry on thinking about the problem.

Thank you all very much for your attendance.

ARTICLE I. Scope of Work

A. The Contractor shall furnish the personnel, materials, equipment and facilities necessary to develop and evaluate the consultation method in establishing and maintaining educational programs for physicians in three hospitals located in depressed areas.

In pursuance of the above, the Contractor shall specifically:

1. Select three (3) hospitals located in depressed areas implement the consultative service to these depressed area hospitals, and institute the actual programs of continuing medical education at these hospitals. The Contractor shall attempt to introduce the following principles of sound educational program development into the hospitals' programs of continuing medical education:

   (a) Secure the participation of representatives of the hospital's physicians in planning and carrying out the programs of continuing medical education

   (b) Obtain data concerning the educational interests and needs of the hospital's physicians as a basis for planning continuing education programs

   (c) Define specific educational objectives based on analysis of the needs and interests of the physicians

   (d) Select educational methods which are most likely to achieve these objectives.

Prior to the onset of the consultative procedures, the Contractor shall translate these four general objectives into specific parameters, in order that their introduction into the educational programs can be objectively measured.

2. Evaluate the effectiveness of the consultation service in aiding depressed area hospitals to establish continuing education programs for their physicians. Specifically, the Contractor shall:

   (a) Make a quantitative analysis of programs initiated and physician participation and response

   (b) Analyze the extent to which the specific parameters of the principles of educational program development enumerated in paragraph 1. above, are incorporated into the programs of continuing medical education at these hospitals.

   The methods and instruments to accomplish this evaluation are to be approved by the Project Officer.

Article I. Scope of Work (Continued)

3. Collect observations and data which shall describe some of the factors, both in the consultative service and in the hospitals, which are important in either aiding or inhibiting the development of programs of continuing medical education within the hospitals. These observations and data shall be used to elucidate objective characteristics, both of the hospital and the consultation service, which might differentially be associated with current or future development of programs of continuing medical education of physicians.

4. Explore methods for evaluating the effects of both program content and techniques of program presentation on the medical practice of participating physicians.

5. Analyze, tabulate, and interpret the data.

6. Identify those characteristics that make hospitals in depressed areas different from those in other communities; such items as attitudes toward continuing education, staffing, turnover rates, etc.

7. Enumerate identifiable differences in continuing education habits of physicians practicing in depressed areas, as opposed to those located in more affluent areas served by the same hospital.

B. In connection with the work and services to be performed above the Contractor shall submit the following reports, in an original and four copies, to the Project Officer:

1. Quarterly Progress Reports

Quarterly Progress Reports in detail consisting of an account of work accomplished, and all important problems encountered.

2. Final Report

A Final Report consisting of:

a. discuss the methodology used in conducting the project

b. Evaluate the effect of the consultation program in establishing programs of continuing education for physicians in the depressed area hospitals and in encouraging the utilization of principles of educational program development in these programs.

c. Discuss those factors (in the hospital and in the consultative services) which are helpful to and a hindrance to the establishment of continuing medical education in hospitals serving depressed areas.

Article I. Scope of Work (Continued)

d. Discuss contrasting characteristics of hospitals located in depressed areas as opposed to those in other communities and enumerate the identifiable differences in these differing environments.

3. Patent Disclosure Reports (See Patent Rights Clause of Contract).

4. The questionnaire forms required to be developed for use under the contract shall be submitted for the review and approval of the Project Officer in sufficient time to allow 3 months for securing Bureau of the Budget Clearances of the forms prior to their use. The work must be scheduled in a manner which will permit the above stated lead-time for clearance without interference with the progress of the work. The Project Officer will be responsible for processing the forms for clearance.

ARTICLE II. Period of Performance

Performance of this contract shall begin on February 3, 1969, and shall not extend beyond the completion date of May 15, 1970, unless the period is extended by modification of the contract.

DEPARTMENT OF
[illegible]
PUBLIC HEALTH SERVICE

CONTRACTOR'S COPY

Contract No. PH 108-70-47
SUPPLEMENTAL AGREEMENT
Modification No. 2

CONTRACT NO.	PAGE 1 OF 2 PAGES
NIH 70-4149	
MODIFICATION NO.	EFFECTIVE DATE
1	September 30, 1970

CONTRACTOR (Name and Address)

Postgraduate Medical Institute
30 Fenway
Boston, Massachusetts 02215

ISSUING OFFICE

Bureau of Health Professions Education and Manpower Training, NIH, PHS
Dept. of Health, Education and Welfare
Building 31, Room 5B-50
Bethesda, Maryland 20014

ACCOUNTING AND APPROPRIATION DATA

Sponsor: Division of Physician Manpower

N/A

PURPOSE: Develop and evaluate the consultation method in establishing and maintaining educational programs for physicians in three hospitals located in depressed areas.

PROJECT DIRECTOR: Norman S. Stearns, M.D.

AMOUNT: N/A

EXPIRATION DATE: December 31, 1970

CONTRACT TYPE: Cost Reimbursement

Except as hereby modified, all terms and conditions of said contract remain unchanged and in full force and effect. This Supplemental Agreement is entered into pursuant to the authority of 41 USC 252 (c) (10).

POSTGRADUATE MEDICAL INSTITUTE
NAME OF CONTRACTOR

BY [signature]
SIGNATURE OF AUTHORIZED INDIVIDUAL

Norman S. Stearns, M.D.
TYPED NAME

TITLE Executive Director

November 20, 1970
DATE

UNITED STATES OF AMERICA

BY [signature]
SIGNATURE OF CONTRACTING OFFICER

Joseph J. Cooney
TYPED NAME

November 30 1970
DATE

PHS-4910-4 (REV. 7/67)

The above numbered contract is hereby modified to provide for an extension in the period of performance, as set forth below:

That portion of Article II., Period of Performance, which reads "September 30, 1970" is changed to read "December 30, 1970".

It is understood and agreed that the above modification results in no change in the total estimated cost of the contract.